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State of Maryland / Department of Health and Mental Hygiene

97 09001

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Pearl Mack</i>				2. Date of Death Month <i>MARCH</i> Day <i>23</i> Year <i>1997</i>				3. Time of Death <i>5:35 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Geriatric Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>Na</i>	
Funeral Director	5. Social Security Number <i>934-22-9844</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>77</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Sept. 16, 1919</i>		9. Birthplace (State or Foreign Country) <i>VA.</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>Md</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <i>5461 Cedonia Avenue</i>				10f. Zip Code <i>21206</i>				10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th Grade</i> College (1-4 or 5+) <i>NA</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic</i>				16b. Kind of Business/Industry <i>Various Trades</i>			
	17. Father's Name (First, Middle, Last) <i>Unknown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Nellie McGlotten</i>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Bobby Wilson</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21212 817 Gilrubin Court Apt.#11 Baltimore, Md.</i>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Voshell Mem. Gardens</i>		Date <i>03-27-97</i>		20c. Location - City or Town, State <i>Dundalk, Md.</i>			
	21. Signature of Funeral Service Licensee <i>Eric M. Smith</i>				22. Name and Address of Facility <i>Baltimore, Maryland</i>					
					WM.C.March FH 1101 E. North Avenue 21202					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Colon Cancer</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>years</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>anemia due to gastrointestinal bleeding</i> <i>insulin dependent diabetes</i> <i>pneumonia</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Cynthia Kuttner-Sands, MD</i>		29c. License number <i>D47451</i>		
29d. Date signed (Month, Day, Year) <i>3/23/97</i>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Cynthia Kuttner-Sands MD, Johns Hopkins Geriatric Center, Baltimore, Maryland 21224</i>		31. Date filed (Month, Day, Year) <i>MAR 26 1997</i>		32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 09002

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLA M. Montgomery

2. Date of Death

3-19-1997 12:56 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-20-9876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-17-1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

536 Gold Street

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse's Aide

16b. Kind of Business/Industry

Ind. General Hosp

17. Father's Name (First, Middle, Last)

William Randall Sr

18. Mother's Name (First, Middle, Maiden Surname)

Lula Virginia Ayers

19a. Informant's Name/Relationship (Type, Print)

Mrs. Kathleen Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1303 Kitmore Rd, Baltimore Md, 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Home 3/4/99 Swings Mills Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2522 W. North Ave. Baltimore Md, 21246

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. RENAL FAILURE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Chronic Atrial Fibrillation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Weber

29c. License number

P10546

29d. Date signed (Month, Day, Year)

03-19-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK WEBER, M.D. 301 ST PAUL PLACE, BALTIMORE MD

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

M. Weber-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



B.K.S

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09003

ITEM:8 per FH-9-745 3-26-97 eoh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL ERIC MACKASON JR.

2. Date of Death

Month Day Year

MARCH 23, 1997

3. Time of Death

11:00PM

4a. Facility Name (If not institution, give street end number)

WASHINGTON COUNTY HOSPITAL E.R.

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

137-66-6405

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

20 Yrs.

8. Date of Birth (Month, Day, Year)

1977 FEB. 18, 1997

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

NJ

10b. County

n/a

10c. City, Town or Location

Long Branch

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

225 Joline Ave.

10f. Zip Code

07740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12th

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

n/a

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

Michael Mackason, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Colbert

19a. Informant's Name/Relationship (Type, Print)

Mildred Colbert/grandmother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

147 Central Ave. Long Branch, NJ 07740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

White Ridge Cemetery

Date

3/31

20c. Location - City or Town, State

Eatontown, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Jackson Funeral Home 242 Neptune Blvd. Neptune, NJ 07753

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wound of Head

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

3-23-97

28b. Time of Injury

2205 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1501 North Ave 21740

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

MARCH 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

26 1997

32. Registrar's Signature

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09004

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLET MARSHALL

2. Date of Death  
Month Day Year

03 23 97

3. Time of Death

14:15

4a. Facility Name (If not institution, give street and number)

University of MARYLAND

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-14-9170

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03/11/25

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

410 E. Gittings Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Frank Lent

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Hoffman

19a. Informant's Name/Relationship (Type, Print)

Oris H. Marshall (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 E. Gittings Street Baltimore Md 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

March 27 1997

20c. Location - City or Town, State

Brooklyn Pk. Md.

21. Signature of Funeral Service Licensee

Daniel A. Hayes

22. Name and Address of Facility

McCully Funeral Home of South Balto.  
130 E. Fort Ave. Baltimore, Md. 21230

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Disseminated Intravascular Coagulation

Due to (or as a consequence of):

Approximate interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

7 days

c. pneumonia

Due to (or as a consequence of):

14 days

d. gangrene of Right foot

14 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

myocardial infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Signature and title of certifier

John Lynn MD

29e. License number

P08550

29f. Date signed (Month, Day, Year)

3/23/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CARA DECKELMAN 22 S. Green Street, Baltimore MD 21201

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in its entirety by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09005

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE G. MARSH.

2. Date of Death

Month Day Year  
March 24, 1997

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

CHESAPEAKE HEALTH CARE CENTER

4b. City, Town, or Location of Death

ARNOLD

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

217-26-3741

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

MARCH 6, 1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

599 "B" STREET

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FACTORY WORKER

16b. Kind of Business/Industry

FACTORY

17. Father's Name (First, Middle, Last)

ROGER TYSON UNGLESBEE

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE EASTERN

19a. Informant's Name/Relationship (Type, Print)

EVELYN SCOTT (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

599 "B" STREET - PASADENA, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK 3/26/97 ELKRIDGE

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LT CVA &amp; RT-HEMIPLEGIA

Due to (or as a consequence of):

ISCHEMIC CEREBRAL INFARCT.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

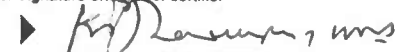
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

012753

29d. Date signed (Month, Day, Year)

3-24-97

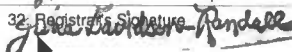
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

K.S. DHARMASENA, MD - 710 CHURCH ST. BALTIMORE, MD 21225

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, II 27 per ME0 G-746 4/1/97 re Certificate of Death

Reg. No.

97 09006

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>WILLIE MORRIS, JR.</b>		2. Date of Death Month Day Year <b>MARCH 22 1997</b>		3. Time of Death <b>3:01 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>3904 BELLE AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>216-50-2288</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>March 22, 1950</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>			
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3524 W. Belvedere Ave.</b>		10f. Zip Code <b>21215</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>African American</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Offset Printer</b>		16b. Kind of Business/Industry <b>Private Industry</b>	
17. Father's Name (First, Middle, Last) <b>Willie J. Morris Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Lee Edwards</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Magnolia Morris (sister)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3524 W. Belvedere Ave. Balto. Md. 21215</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Balto. Cemetery</b>		20c. Location - City or Town, State <b>3/29/97 Balto. Md.</b>	
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CONGENITAL CORONARY ARTERY ANOMALY</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>MARCH 23, 1997</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>		32. Registrar's Signature <b>[Signature]</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09007

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

EVA NORFOLK

2. Date of Death

March 25 1997 2:30 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL Hospital Glen Burnie ANNE ARUNDEL

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

232-01-8949

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

March 31, 1916

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

525 North Charles Street

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

7th

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William J. LeHew

18. Mother's Name (First, Middle, Maiden Surname)

Mae H. Dick

19a. Informant's Name/Relationship (Type, Print)

Doris Shipp ( Neice)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6810 Sunnyside Lane Fort Washington, MD. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenmount Cemetery

Date

3/26/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Daniel A. Taylor

22. Name and Address of Facility

McCully Funeral Home of South Baltimore  
130 E. Fort Ave. Balto., MD. 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Approximate  
Interval Between  
Onset and Death

1 Hour

Due to (or as a consequence of):

b. PNEUMONIA

30 DAYS

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Mae H. Dick, M.D.

29c. License number

D 46962

29d. Date signed (Month, Day, Year)

MARCH 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SHIRAZI, M.D. HOUSE PHYSICIAN, NORTH ARUNDEL HOSPITAL.

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

John Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09008

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Penny Norfolk

2. Date of Death

Month Day Year  
March 24 97

3. Time of Death

9:30 am

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

218-90-9159

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 20 1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel Co.

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

218 Pinewood Drive

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

Collage (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Super Fresh

17. Father's Name (First, Middle, Last)

John E. Norfolk

18. Mother's Name (First, Middle, Maiden Surname)

Alpha Jane Shore

19a. Informant's Name/Relationship (Type, Print)

Alpha Jane Norfolk (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

218 Pinewood Drive, Pasadena Md. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Glen Haven Mem. Park

Date

March 28  
1997

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

Daniel A. Shore

22. Name and Address of Facility

McCully Funeral Home of Pasadena  
3204 Mountain Road Pasadena Md. 2112223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. cerebellar hematoma

Approximate  
Interval Between  
Onset and Death

36 hours

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cocaine usage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John E. Shore

29c. License number

P10036

29d. Date signed (Month, Day, Year)

3/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara E. Lazio, 225. Greene St Baltimore MD 21201

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09009

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAULINE

E/

OPPENHEIMER

2. Date of Death

MAR. 18

1997

3. Time of Death

2:40PM

4a. Facility Name (If not institution, give street and number)

PIKESVILLE NURSING HOME

4b. City, Town, or Location of Death

PIKESVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-28-5700

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 19, 1895

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2500 W. BELVEDERE AVE., APT. 303

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

PHILIP

PHILLIPS

18. Mother's Name (First, Middle, Maiden Surname)

IDA

KRAVITZKY

19a. Informant's Name/Relationship (Type, Print)

GORDON OPPENHEIMER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5809 NICHOLSON LA., UNIT 11, N. BETHESDA, MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON (CHIZUK AMUNO)

Date

3/21/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

*Michael Bruger*

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

A acute myocardial infarct acute

b.

Due to (or as a consequence of):

Arteriosclerotic cardiovascular disease

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*H. Gerald Oster MD*

29c. License number

D-16080

29d. Date signed (Month, Day, Year)

3-18-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3635 Old Court Road Pikesville Md 21208

31. Date filed (Month, Day, Year)

MAR 25 1997

32. Registrar's Signature

*Julia Jackson-Rendell*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", a form shall be shown any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09010

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia M. Pelto

2. Date of Death

March 24, 1997

3. Time of Death

6:45AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

22 Carriage Walk Ct.

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

5. Social Security Number

213-20-2861

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov 26, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22 Carriage Walk Ct.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Baltimore County Board of Education

17. Father's Name (First, Middle, Last)

Richard McNicholas

18. Mother's Name (First, Middle, Maiden Summa)

Catherine Parks

19a. Informant's Name/Relationship (Type, Print)

Peter B. Pelto / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Carriage Walk Ct. Parkville, Md 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel - Bel Air

Date

March 25, 1997

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Failure

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate

Many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D23829

29d. Date signed (Month, Day, Year)

March 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Albert Deloskey 515 Fairmount Ave. Towson, Maryland 21286

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09011

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Catherine Poleski

2. Date of Death

March 21, 1997

Day Year

3. Time of Death

1640

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

213-20-8504

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 5, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9033 Cuckold Point Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Riveter

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Joseph Francis Barnhouser

18. Mother's Name (First, Middle, Maiden Summa)

Agnes Tolsdzicki

19a. Informant's Name/Relationship (Type, Print)

Michael J. Poleski/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9033 Cuckold Pt. Road Edgemere, Maryland 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery 3/25/1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave., Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicidal 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35761

29d. Date signed (Month, Day, Year)

3/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Fingerhord M.D. Johns Hopkins Bayview Med Ctr 21224

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09012

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bertha Penn

2. Date of Death

March 24th 1997 12:50PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

400-34-1812

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 4, 1907

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1180 Cleveland St.

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Spurlock

18. Mother's Name (First, Middle, Maiden Surname)

Perlina Ross

19a. Informant's Name/Relationship (Type, Print)

Bertha Smith - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1180 Cleveland St., Balto., Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

3/28/97

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge

7250 Washington Blvd., Elkridge, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Bilateral Pneumonia

2 days

Due to (or as a consequence of):

b. History of Breast Cancer

1 year

Due to (or as a consequence of):

c. Cerebrovascular Accident

Due to (or as a consequence of):

d. Dehydration

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attending

D38993

29c. License number

D38993

29d. Date signed (Month, Day, Year)

3/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kermon Aldermy 2600 liberty Hgts Baltimore MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

... Aldermy

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the hospital or attending physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the funeral director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

... ..

— — — — —

[illegible]

1. *Chlorophyll a* and *Chlorophyll b* content of the leaves of *C. sinensis* and *C. indica* were determined by spectrophotometry. The leaves were ground in a mortar and pestle with liquid nitrogen and extracted with 80% methanol. The extract was centrifuged at 10,000g for 10 min and the supernatant was transferred to a clean vial. The absorbance of the supernatant was measured at 663 nm and 646 nm. The concentration of chlorophyll a and b was calculated using the following equations:

1

100

*Journal of Management Education*

—

1

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State of Maryland / Department of Health and Mental Hygiene

97 09013

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MICHAEL F. PAJTIS</b>						2. Date of Death Month <b>MARCH</b> Day <b>24</b> Year <b>1997</b>		3. Time of Death <b>8:58 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Church Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-20-2431</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5/1/1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2119 Bank Street</b>				10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean War</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>			16b. Kind of Business/Industry <b>Stationary</b>			
17. Father's Name (First, Middle, Last) <b>Michael B. Pajtis</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Estella Price</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Bernice Pajtis Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2119 Bank Street Baltimore, MD 21231</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Stanislaus Cemetery</b>		20c. Date <b>3/28/97</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>David J. Weber Funeral Homes 401 S. Chester St. Baltimore, MD 21231</b>						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): b. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death <b>1 day</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RESPIRATORY FAILURE</b> <b>PNEUMONIA</b> <b>HYPERTENSION</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <b>N/A</b>		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier MD				29c. License number <b>D25027</b>		29d. Date signed (Month, Day, Year) <b>MARCH 24, 1997</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VIJAY M. ABHYANKAR, CHURCH HOME &amp; HOSPITAL, 100 N. BROADWAY, BALTIMORE</b>										
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





## Certificate of Death

Reg. No.

97 09014

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DEON

PARKER

2. Date of Death

Month

Day

Year

MARCH 20

1997

3. Time of Death

3:41 P.M.

4a. Facility Name (If not institution, give street and number)

SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-62-1386

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

JAN. 5, 1954

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3708 PARK HEIGHTS AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CONSTRUCTION COMPANY

17. Father's Name (First, Middle, Last)

VERNON M. BANKS

18. Mother's Name (First, Middle, Maiden Surname)

LOIS L. DIVERS

19a. Informant's Name/Relationship (Type, Print)

LOIS PARKER (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3708 PARK HEIGHTS AVE. BALTIMORE, MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. CALVARY CEMETERY 3-26-97 BALTIMORE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P. A.  
2146 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACQUIRED IMMUNE DEFICIENCY SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARYANN A. KORON M. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Papers 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09015

Item: 23a part I per MEO G-749 7/14/97 dh  
Items: 23 part I, 27 per MEO G-746 4/24/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID POPE</b>				2. Date of Death Month <b>MARCH</b> Day <b>23</b> Year <b>1997</b>		3. Time of Death <b>07:44 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>214-58-8448</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>October 29, 1951</b>			
	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>2852 Boorman Avenue</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10<sup>th</sup> grade</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Kitchen Worker</b>			16b. Kind of Business/Industry <b>New Hanover Memorial Hospital</b>		
	17. Father's Name (First, Middle, Last) <b>Summie Pope</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Seldon</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Brenda Bridges</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>410 Millhouse Road, Castle Hayne, North Carolina 28427</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Date <b>3/6/97</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph H. Brown Jr. Funeral Home</b> <b>2140 N. Fulton Avenue, Baltimore, Maryland 21217</b>					
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>ACUTE MYOCARDITIS</b> <b>HYPERTROPHIC CARDIOMYOPATHY</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>MARCH , 1997</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Aaron Wakefield</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09016

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN G. PHELPS

2. Date of Death

Month  
MARCH

Day

21

Year

1997

3. Time of Death

12:00PM

4a. Facility Name (If not institution, give street and number)

4934 GATEWAY TERRACE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

214-20-1842

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Min.

(Month, Day, Year)

FEB 21, 1926

9. Birthplace (State or Foreign Country)

BALTIMORE

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4934 GATEWAY TERRACE

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH GRADE

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CAR MEN

16b. Kind of Business/Industry

B &amp; O RAILROAD

17. Father's Name (First, Middle, Last)

JOHN WILLARD

18. Mother's Name (First, Middle, Maiden Surname)

EVA PHELPS

19a. Informant's Name/Relationship (Type, Print)

JOYCE A. BRANAM (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4916 CEDAR GARDEN ROAD - BALTIMORE, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRISON FOREST VETS CEM

Date

3/26/97

20c. Location - City or Town, State

OWINGS, MILLS, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)*Acute Myocardial Infarct*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last*Coronary Arteriosclerosis*  
Due to (or as a consequence of):  
*High Blood Pressure*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Wt Loss*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

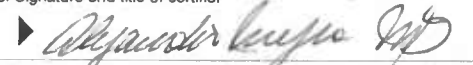
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28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 08780

29d. Date signed (Month, Day, Year)

3/21/97

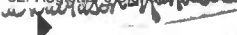
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. ALEJANDRO MEJIA - 405 FREDERICK ROAD-SUITE 100-CATONSVILLE, MD. 21228

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

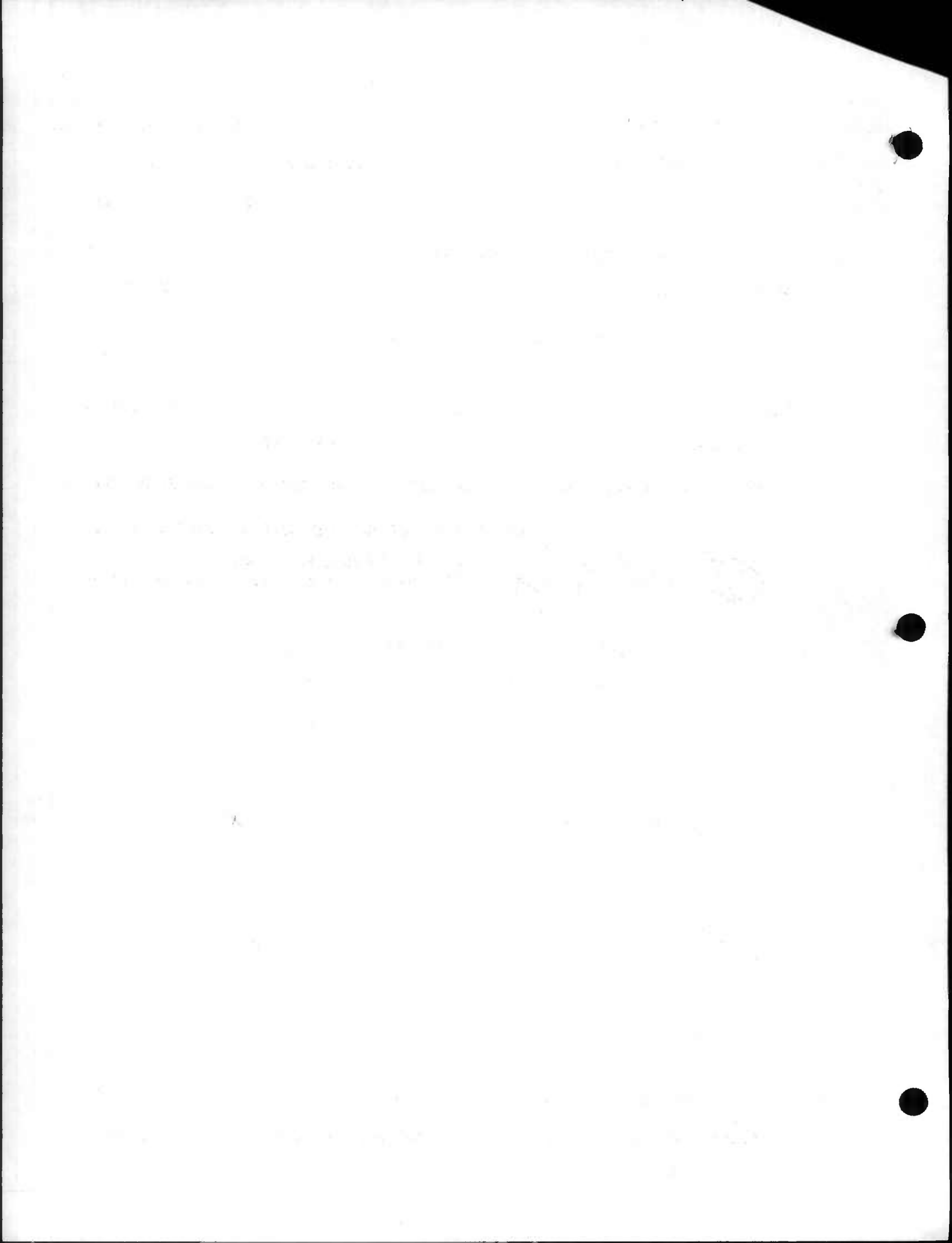
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09017

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEULAH PEREGOY				2. Date of Death Month Day Year MARCH 21, 1997				3. Time of Death 9:45 A.M.	
	4e. Facility Name (If not institution, give street and number) MARINER NURSING HOME (SUMMIT)				4b. City, Town, or Location of Death CATONSVILLE				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-03-9607		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) NOV 15, 1901		9. Birthplace (State or Foreign Country) BALTIMORE	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 2 BLOOMINGDALE AVENUE				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (14 or 5+) 6TH GRADE				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF-EMPLOYED				16b. Kind of Business/Industry CARNIVAL	
	17. Father's Name (First, Middle, Last) ORMANDL WHITTER				18. Mother's Name (First, Middle, Maiden Surname) EMMA J. DGEN					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BEULAH E. PAUL (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 WILKENS AVENUE-BALTIMORE, MD. 21229					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		Date 3/24/97		20c. Location - City or Town, State BALTIMORE			
	21. Signature of Funeral Service Licensee <i>Jackie H. Shannon</i>				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Myocardial Infarction</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <i>Hours</i>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic gastrointestinal bleeding</i> <i>Arteriosclerosis of the lungs</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <i>MD</i>		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>MD</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>Charles R. Grant</i>				29c. License number 024781		29d. Date signed (Month, Day, Year) 3/26/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES R. GRANT MD 716 MANDER CHURCH LANE S306 BALTIMORE MD 21229										
31. Date filed (Month, Day, Year) MARCH 26 1997				32. Registrar's Signature <i>Jane Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09018

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY

L.

RADOCK

2. Date of Death

MARCH 21, 1997

3. Time of Death

1:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

217 24 2134

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 5 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8304 Wilson Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Downs Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Mitchell

19a. Informant's Name/Relationship (Type, Print)

Stephen Radock husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8304 Wilson Ave. Parkville, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

March 25 1997

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

L. R. K. K. K.

22. Name and Address of Facility

EVANS Chapel of Memories

8800 Harford Rd. Baltimore MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RECURRENT LUNG CANCER

5 YEARS

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

5 YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Natividad D. de Leon, M.D.

29c. License number

D19508

29d. Date signed (Month, Day, Year)

21st March 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIVIDAD DELEON, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death. The Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09019

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OLIVE RACHUBA</b>				2. Date of Death Month Day Year <b>MARCH 24 1997</b>		3. Time of Death <b>1:05 PM</b>										
	4e. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON, MARYLAND</b>		4c. County of Death <b>BALTIMORE</b>										
Funeral Director	5. Social Security Number <b>216-05-2899</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 31, 1905</b>										
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>										
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>9644 Oakdale Ave.</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 yrs.</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>												
	17. Father's Name (First, Middle, Last) <b>Charles Gardner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth unknown</b>												
	19a. Informant's Name/Relationship (Type, Print) <b>Joseph Rachuba / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9644 Oakdale Ave. Parkville, Maryland 21234</b>												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. Location - City or Town, State <b>March 27, 1997 Rosedale, Maryland</b>												
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Evans Chapel of Memories</b>		22. Name and Address of Facility <b>8800 Harford Rd. Baltimore, Md 21234</b>												
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>ASPIRATION PNEUMONIA</b></td> <td>2 WEEKS</td> </tr> <tr> <td>b. <b>SWALLOWING PATHOLOGY</b></td> <td>2 WEEKS</td> </tr> <tr> <td>c. <b>ATRIAL FIBRILLATION</b></td> <td>2 WEEKS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>ASPIRATION PNEUMONIA</b>	2 WEEKS	b. <b>SWALLOWING PATHOLOGY</b>	2 WEEKS	c. <b>ATRIAL FIBRILLATION</b>	2 WEEKS	d.	
	Immediate Cause (Final disease or condition resulting in death)	a. <b>ASPIRATION PNEUMONIA</b>	2 WEEKS														
b. <b>SWALLOWING PATHOLOGY</b>		2 WEEKS															
c. <b>ATRIAL FIBRILLATION</b>		2 WEEKS															
d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier , M.D.				29c. License number <b>D50283</b>		29d. Date signed (Month, Day, Year) <b>3 / 26 / 1997</b>											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DINA A DARWISH, M.D. 2360 W. JOPPA ROAD, LUTHERVILLE, MARYLAND</b>																	
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>				32. Registrar's Signature 													

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and duly filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09020

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT ROSSO

2. Date of Death

Month

Day

Year

MARCH 12 1997

3. Time of Death

11:30 P.M.

4e. Facility Name (If not institution, give street and number)

EASTPOINT NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218-09-7353

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

1-7-20

9. Birthplace (State or Foreign

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2932 HUDSON STREET

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

PRINTER

16b. Kind of Business/Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

SEBASTIAN ROSSO

18. Mother's Name (First, Middle, Maiden Surname)

CAROLINE NATALE

19a. Informant's Name/Relationship (Type, Print)

MS. RITA ROSSO

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2932 HUDSON STREET BALTO. MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARISON FOREST VA CEM 3-17

Date

20c. Location - City or Town, State

A. A. CO. MD.

21. Signature of Funeral Service Licensee

Charles R. Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME

1201 DUNDALK AVENUE BALTO. MD. 21222

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Pneumonia

b.

Due to (or as a consequence of):

Emphysema

c.

Due to (or as a consequence of):

Anemia

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Angiodysplasia

peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 44796

29d. Date signed (Month, Day, Year)

3-13-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

9512 HARTFORD ROAD, BALTIMORE, MD 21234

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09021

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Reed

2. Date of Death

Month - 3 - 23 - 1997 Year

3. Time of Death

1:15 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1808 Madison Ave. 3rd Floor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-03-8644A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Sept. 11, 1908 Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1808 Madison Ave.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

Afro-American

14. Race - American Indian, Black, White, etc.

Specify:

Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Own Restaurant

17. Father's Name (First, Middle, Last)

William Tyler

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Clemons

19a. Informant's Name/Relationship (Type, Print)

Mrs. Margaret Price (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1808 Madison Ave. Balto. Md. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial

Date

3/26/97

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home

2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Thyroid Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1983

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Adrian Dobs, M.D.

29c. License number

D28007

29d. Date signed (Month, Day, Year)

3/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adrian Dobs, M.D., Johns Hopkins Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Registrar: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Registrar: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09022

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES

SCHIAVONE

2. Date of Death

Month Day Year  
MARCH 25, 1997

3. Time of Death

6:25 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

205-12-8118

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 8, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

201 N. Essex Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Muolo

18. Mother's Name (First, Middle, Maiden Summa)

Marian Calabretta

19a. Informant's Name/Relationship (Type, Print)

Orlando C. Schiavone (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 N. Essex Ave. Baltimore, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holly Hill Mem. Gardens 3/27/1997

Date

20c. Location - City or Town, State

Baltimore, Co. Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

RESPIRATORY FAILURE

Due to (or as a consequence of):

CARCINOMATOSIS WITH PLEURAL EFFUSION

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

BREAST CANCER

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC HEART DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 37254

29d. Date signed (Month, Day, Year)

3-25-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, MD, 7620 YORK ROAD, TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09023

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emile Adams Sullivan</b>				2. Date of Death Month <b>March</b> Day <b>23</b> Year <b>1997</b>		3. Time of Death <b>3:28pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care, Ruxton</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore County</b>	
Funeral Director	5. Social Security Number <b>195-01-2385</b>		6. Sex <b>XX</b> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 22, 1902</b>	
	9. Birthplace (State or Foreign Country) <b>Balto. Md.</b>		10a. State <b>MD</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Towson</b>	
Usual Residence of Decedent								
10a. State <b>MD</b>			10b. County <b>Baltimore Co.</b>			10c. City, Town or Location <b>Towson</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>7001 Charles St.</b>			10f. Zip Code <b>21204</b>		
10g. Citizen of What Country? <b>USA</b>			11. Marital Status <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Executive</b>			16b. Kind of Business/Industry <b>Financial</b>			17. Father's Name (First, Middle, Last) <b>Charles F. Sullivan</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Burgess</b>			19a. Informant's Name/Relationship (Type, Print) <b>Bernard C. Kirby nephew</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 Dunkirk Road Baltimore, Md. 21212</b>		
20a. Method of Disposition <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cem. 3/26/97 Baltimore, Md.</b>			20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>John D. Mitchell IV</b>			22. Name and Address of Facility <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</b>			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>TRANSITIONAL CELL CARCINOMA of BLADDER</b>		
23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>TRANSITIONAL CELL CARCINOMA of BLADDER</b>			23c. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown			24a. Was an autopsy performed? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No			25. Was case referred to medical examiner? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <b>2</b> <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>3-23-97</b>			28b. Time of Injury <b>M</b>		
28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>AH Ghiladi, MD</b>			29c. License number <b>D-12849</b>		
29d. Date signed (Month, Day, Year) <b>3-23-97</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AH GHILADI, MD 7600 OSLER Dr. TOWSON, MD 21204</b>			31. Data filed (Month, Day, Year) <b>MAR 26 1997</b>		
32. Registrar's Signature <b>Edson-Randall</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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1971

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

97-1163-003

Item: 5 per F.H. G-746 4/29/97 re  
Items: 23 part I, 27 per MEO G-746 4/29/97 re

State of Maryland / Department of Health and Mental Hygiene

97 09024

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katelyn Paige Stephens				2. Date of Death Month Day Year March 5, 1997		3. Time of Death 12:05 PM		
	4a. Facility Name (If not Institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 219-45-1240	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 17, 1995		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md.	10b. County Howard	10c. City, Town or Location Highland			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 13450 Pond Field Court				10f. Zip Code 20777		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant		16b. Kind of Business/Industry Infant				
	17. Father's Name (First, Middle, Last) Matthew William Stumpf				18. Mother's Name (First, Middle, Maiden Surname) Kelly Joy Stephens				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ray Stephens - grandfather				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13450 Pond Field Court, Highland, Md. 20777				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. Location - City or Town, State Elkridge, Md.		20d. Date 3/10/97		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Kaufman Funeral Home at Meadowridge 7250 Washington Blvd., Elkridge, Md. 21227				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. PRIMARY APNEA OF INFANCY Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 6, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAR 26 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.


Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Items: 23 part I, 27, 28a-f per MEO G-746 4/1/97

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANTHONY STONES</b>				2. Date of Death Month <b>MARCH</b> Day <b>24</b> , Year <b>1997</b>		3. Time of Death <b>1:47 PM.</b>							
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL BAYVIEW</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>							
Funeral Director	5. Social Security Number <b>220-92-3342</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>30 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 1, 1966</b>	9. Birthplace (State or Foreign Country) <b>MD</b>						
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number <b>2011 Dundalk Ave.</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>							
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> <b>1 yr.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeping</b>			16b. Kind of Business/Industry <b>Old Court Nursing HM</b>						
	17. Father's Name (First, Middle, Last) <b>Harvey Stones, Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lavenia Brown</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Lavenia Stones/mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>716 Newpittsburg Ave. Balto., MD 21222</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>3/29</b>		20c. Location - City or Town, State <b>Randallstown, MD</b>							
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>James A. Morton &amp; Sons Funeral Home 1701 Laurens St. BALTO., MD 21217</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. COCAINE INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>									Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown														
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No									24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) <b>found 3/24/97</b>		28b. Time of Injury <b>unknown</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Unknown</b>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Found at home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2011 Dundalk Ave. Dundalk, Md.</b>											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MARCH 25, 1997</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>														
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>									32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09026

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONARD JOHN SASS, SR.</b>				2. Date of Death Month <b>Mar</b> Day <b>22</b> Year <b>1997</b>				3. Time of Death <b>1:00 AM</b>																															
	4a. Facility Name (If not institution, give street and number) <b>93 Kingbrook Road 21090</b>				4b. City, Town, or Location of Death <b>Linthicum</b>				4c. County of Death <b>Anne Arundel</b>																															
Funeral Director	5. Social Security Number <b>218-05-6074</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 16, 1919</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>																															
	Usual Residence of Decedent																																							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Linthicum</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
	10e. Street and Number <b>93 Kingbrook Road</b>				10f. Zip Code <b>21090</b>		10g. Citizen of What Country? <b>USA</b>																																	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW 2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Trucking Co. Owner</b>				16b. Kind of Business/Industry <b>Sass Bros. and Md. Concrete Cos.</b>																																	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>John Sass</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Brywczynski</b>																																			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Fay Aileen Sass (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>93 Kingbrook Road, Linthicum, Maryland 21090</b>																																			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Pk. Mar. 25, 1997</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>																																			
	21. Signature of Funeral Service Licensee <b>Kevin E. Ecker</b>				22. Name and Address of Facility <b>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Baltimore, Md. 21225-1856</b>																																			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																							
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225</b>																																								
<table border="0"> <tr> <td colspan="2">31. Date filed (Month, Day, Year) <b>MAR 26 1997</b></td> <td colspan="8">32. Registrar's Signature <b>Davidson-Randall</b></td> </tr> </table>										31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>		32. Registrar's Signature <b>Davidson-Randall</b>																												
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Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09027

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Warfield Scott

2. Date of Death

March 23, 1997 Year

3. Time of Death

1:15 a.m.

4a. Facility Name (If not institution, give street and number)

Heron Point

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

217-46-3297

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 4, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

23673 Fox Point Farm Lane

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Nicholas Warfield

18. Mother's Name (First, Middle, Maiden Surname)

Florence Colton

19a. Informant's Name/Relationship (Type, Print)

Ms. H. Louise S. Widdup/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23673 Fox Point Farm Lane, Chestertown, MD 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

3-27-97

20c. Location - City or Town, State

Highland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.

Ellicott City, Maryland 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONTRIBUTORIAL ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-13824

29d. Date signed (Month, Day, Year)

3-24-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. John Seymour, 122 Speer Road, Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

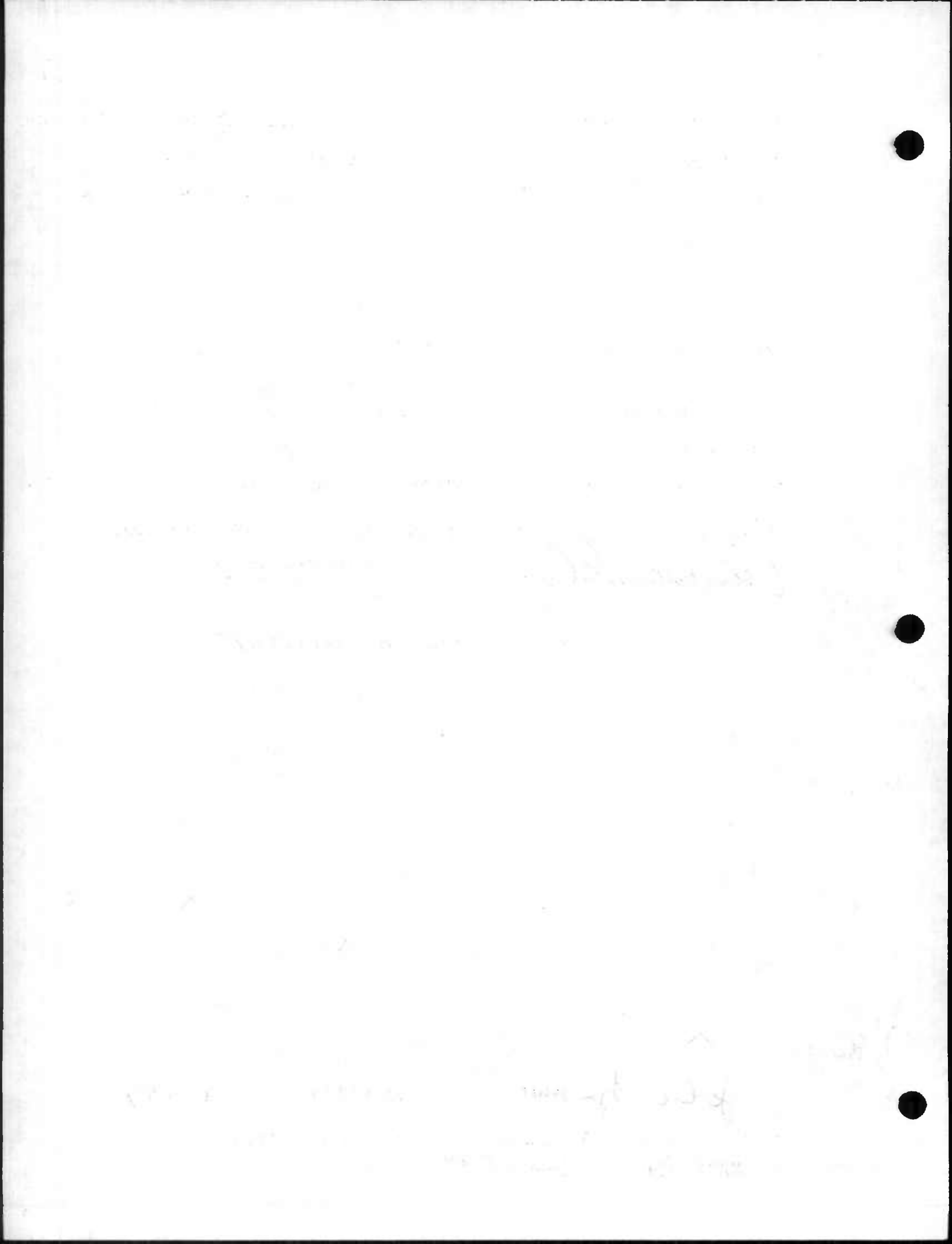
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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09028

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSLYN SIEGEL</b>				2. Date of Death Month <b>MARCH</b> Day <b>17</b> Year <b>1997</b>				3. Time of Death <b>8:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>WILLIAM HILL MANOR NURSING HOME</b>				4b. City, Town, or Location of Death <b>EASTON</b>				4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>098-16-3380</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 25, 1900</b>		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>501 DUTCHMANS LANE</b>				10f. Zip Code <b>21601</b>				10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>SECRETARY</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>				16b. Kind of Business/Industry <b>U.S. NAVY</b>	
	17. Father's Name (First, Middle, Last) <b>MORRIS MAHLER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>IDA UNKNOWN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>FRED H. SIEGEL (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 KEEL HAUL DR. GRASONVILLE, MD 21638</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OLD MONTEFIORE</b>		Date <b>3/23/1997</b>		20c. Location (City or Town, State) <b>QUEENS, NY</b>			
	21. Signature of Funeral Service Licensee <i>Ellenae Levinson</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>sepsis undetermined origin</b> days Due to (or as a consequence of): b. <b>chronic debilitated state</b> months Due to (or as a consequence of): c. <b>dementia</b> years Due to (or as a consequence of): d. <b>arteriosclerotic cardiovascular disease</b> years  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how Injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Robert B. Sanchez M.D.</i>										
29c. License number <b>D25750</b>										
29d. Date signed (Month, Day, Year) <b>3/17/97</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT B. SANCHEZ M.D. 508 Ed/willd Ave Easton, MD 21601</b>										
31. Date filed (Month, Day, Year) <b>MAR 25 1997</b>										
32. Registrar's Signature <i>Julia Davidson-Randall</i>										

Baltimore, Maryland 21215-0026  
Permit. Pages 1 and 2 should be filed within 72 hours and death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or "item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09029

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sidney Shrog</i>				2. Date of Death Month <i>March</i> Day <i>17</i> Year <i>1997</i>		3. Time of Death <i>2230</i>	
	4a. Facility Name (If not Institution, give street and number) <i>Northwest Hospital Center</i>				4b. City, Town, or Location of Death <i>Randallstown</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>214-24-2197</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>69</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>SEPT. 23, 1927</i>	9. Birthplace (State or Foreign Country) <i>MARYLAND</i>
	Usual Residence of Decedent							
10a. State <i>MD</i>		10b. County <i>BALTIMORE</i>		10c. City, Town or Location <i>BALTIMORE</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>3616 YENNAIR LANE, APT. 3-A</i>				10f. Zip Code <i>21244</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>PRINTER</i>			16b. Kind of Business/Industry <i>PRINTING</i>	
17. Father's Name (First, Middle, Last) <i>BARNEY SHROG</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>SARAH LEVINSON</i>				
19a. Informant's Name/Relationship (Type, Print) <i>MAURICE OFFIT, ATTY.</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8 PARK CENTER CT., SUITE 200 OWINGS MILLS, MD 21117</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GREATER BALTO. LODGE</i>		Date <i>3/20/97</i>		20c. Location - City or Town, State <i>BALTIMORE, MD</i>
21. Signature of Funeral Service Director <i>[Signature]</i>				22. Name and Address of Facility <i>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>MRSA Sepsis</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>7 days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Multiple organ system failure including renal &amp; hepatic, Diabetes mellitus, HTN</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature] MD</i>		29c. License number <i>D 35844</i>		29d. Date signed (Month, Day, Year) <i>March 17, 1997</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>D. Roggen 5401 Old Court Road Randallstown MD 21133</i>								
31. Date filed (Month, Day, Year) <i>MAR 25 1997</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," check 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09030

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Beverly M. Steinhorn</i>				2. Date of Death Month <i>March</i> Day <i>22</i> Year <i>1997</i>		3. Time of Death <i>7 AM</i>	
	4a. Facility Name (If not institution, give street and number) <b>PIKESVILLE NURSING HOME</b>				4b. City, Town, or Location of Death <b>PIKESVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-22-6269</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 21, 1927</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
Usual Residence of Decedent								
10e. State <b>MD</b>			10f. Zip Code <b>21208</b>			10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business/Industry <b>STATE OF MARYLAND</b>		
17. Father's Name (First, Middle, Last) <b>ISADORE STEINBERG</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>REBECCA SCHWARTZ</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MORTON STEINHORN (HUSBAND)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7424 KATHYDALE RD. BALTIMORE, MD 21208</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN</b>		20c. Location - City or Town, State <b>3/24/97 BALTIMORE, MD</b>			
21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i>					22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Metastatic Pancreatic Cancer</i> Due to (or as a consequence of): <i>with liver and lung metastases</i>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>heart failure</i>  Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertensive Arteriosclerotic Cardiovascular Disease with Congestive heart failure</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Joseph J. DeWitt</i>					29c. License number <b>DOZ-053</b>		29d. Date signed (Month, Day, Year) <b>3-22-97</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSEPH DEWITT M.D. 3635 OLD AT. RD. PICO, MD 21208</b>								
31. Date filed (Month, Day, Year) <b>MAR 25 1997</b>					32. Registrar's Signature <i>Julia Taylor-Pendleton</i>			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09031

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ida ruth schocket					2. Date of Death Month: March Day: 19 Year: 1997		3. Time of Death 4:40 a.m.		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore					4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 212-74-3652		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 22, 1906		9. Birthplace (State or Foreign Country) RUSSIA	
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 6807 Park Heights Ave, Apt. 3-A					10f. Zip Code 21215		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 Collega (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Morris Tublin					18. Mother's Name (First, Middle, Maiden Summa) Leah Margolis					
19a. Informant's Name/Relationship (Type, Print) Dr. Stanley Schocket (Son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 Anton Farms Road Baltimore, MD 21208					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Shaarei Zion -			Date 3-20-1997		20c. Location - City or Town, State Rosedale, MD		
21. Signature of Funeral Service Licensee Ellensue Lewinson					22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Bacterial sepsis Due to (or as a consequence of): b. Uremia Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoporosis, Chronic obstructive pulmonary disease, aortic valve replacement										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Julia Davidson-Randall					29c. License number 4K-9062		29d. Date signed (Month, Day, Year) March 19, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Kanesbige 2401 W. Belvedere Ave. Baltimore, MD 21215										
31. Date filed (Month, Day, Year) MAR 25 1997					32. Registrar's Signature Julia Davidson-Randall					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09032

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William McKinnly Vicks Jr.</b>				2. Date of Death Month <b>March</b> Day <b>15</b> Year <b>1997</b>		3. Time of Death <b>8:47 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Liberty Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>228-01-8035</b>		6. Sex <b>X</b> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth Month <b>March</b> Day <b>7</b> Year <b>1913</b>	
	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>517 Robert St.</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plumber</b>		16b. Kind of Business/Industry <b>Denmark Corp.</b>	
	17. Father's Name (First, Middle, Last) <b>William McKinnly Vicks Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Vicks</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Ernestine Bonds (Sister-in-law)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>517 Robert St. Balto. Md. 21217</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		20c. Location - City or Town, State <b>3/21/97 Lansdowne, Md.</b>			
	21. Signature of Funeral Service licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Hypertensive Heart Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>Minutes</b> <b>10 years</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Joseph L. Russ</b>				29c. License number <b>D14900</b>		29d. Date signed (Month, Day, Year) <b>3-17-97</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>1721 PENNSYLVANIA AVE BALTIMORE, MD. 21217</b>								
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>				32. Registrar's Signature <b>Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09033

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Renee Bernice Williams</b>				2. Date of Death Month <b>March</b> Day <b>24</b> Year <b>1997</b>		3. Time of Death <b>10:28 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince Georges Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>577-94-4074</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Feb. 7, 1962</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Prince Georges</b>	10c. City, Town or Location <b>New Carrollton</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number <b>7713 Riverdale Rd - Heritage Sq #304</b>			10f. Zip Code <b>20784</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Janitorial</b>		16b. Kind of Business/Industry <b>School Board</b>			
	17. Father's Name (First, Middle, Last) <b>Kent Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Doris Holland</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Doris M. Williams/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7713 Riverdale Rd #304 New Carrollton, Md. 20784</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Shiloh Cemetery</b>		Date <b>3/29/97</b>		20c. Location - City or Town, State <b>McLean, Virginia</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ames Funeral Home, Inc. 8914 Quarry Road - Manassas, Va. 20110</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>&lt;30 mts</b></p> <p>b. <b>RESPIRATORY INSUFFICIENCY</b> Due to (or as a consequence of): <b>&gt;2-monthly</b></p> <p>c. <b>ANOXIC ENCEPHALOPATHY</b> Due to (or as a consequence of): <b>&gt;2-monthly</b></p> <p>d.</p>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure disorder.</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D-34525</b>		29d. Date signed (Month, Day, Year) <b>03-25-97</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. J. RAO, MD; 4000-Mitchellville Road; #220; Bowie-20716.</b>								
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09034

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY

WOOD

2. Date of Death  
Month Day Year  
MARCH 21 19973. Time of Death  
7:55 AM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-34-5151

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth  
(Month, Day, Year)

SEPT 18, 1901

9. Birthplace (State or Foreign Country)

MASS.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rogers Forge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

334 OLD TRAIL

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Thomas J. OLYS

18. Mother's Name (First, Middle, Maiden Summa)

Charlotte E. McLeary

19a. Informant's Name/Relationship (Type, Print)

Leonard Wood /SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11952 MAYS CHAPEL Rd. Timonium, Md. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARLINGTON NATIONAL CEM

Date

March 26  
1997

20c. Location - City or Town, State

ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

2325 YORK Rd  
TIMONIUM, Md. 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

P15504

29d. Date signed (Month, Day, Year)

3-21-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Edward Nakhuda

2300 DULANEY Valley Rd. Towson, Md. 21204

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09035

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Williams

2. Date of Death

Mar. 21 1997

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

240-32-6829

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 30, 1916

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

md

10b. County

Baltimore

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

William T. Bembry

18. Mother's Name (First, Middle, Maiden Surname)

Lugenia Skinner

19a. Informant's Name Relationship (Type, Print)

James Bembry - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4350 Columbia Rd. Ellicott City, Md 21042

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Eden Cemetery

Date

3-24-97

20c. Location - City or Town, State

Philadelphia, Pa

21. Signature of Funeral Service Licensee

John March

22. Name and Address of Facility

March F/H West  
4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CVA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

D E M E N T I A

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John March

29c. License number

D25686

29d. Date signed (Month, Day, Year)

3-21-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABRAHAM IPAKCHI MD 7600 OSLER DRIVE BALTIMORE MD 21204

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

Gina Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09036

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HUNIE ELIZABETH WILSON

2. Date of Death

Month Day Year  
MARCH 23 97

3. Time of Death

1135 A

4a. Facility Name (If not institution, give street and number)

DEATON NURNING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

228 22 6049

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

7/18/24

9. Birthplace (State or Foreign Country)

V.A.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1218 ARGYLE AVE.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

AFRO

Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER AIDE

16b. Kind of Business/Industry

BALTIMORE CITY

17. Father's Name (First, Middle, Last)

WILLIE SMITH

18. Mother's Name (First, Middle, Maiden Surname)

ESTELLE SMITH

19a. Informant's Name/Relationship (Type, Print)

RONALD WILSON SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1218 ARGYLE AVE. BALTO. MD. 21217

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS PARK

Date

20c. Location - City or Town, State

ARBUTUS, MD.

21. Signature of Funeral Service Licensee

Estep Brothers

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

STATUS POST CORONARY ARTERY BYPASS GRAFT

Due to (or as a consequence of):

8 months

c.

ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MEDIASTINITIS: RESPIRATORY FAILURE SECONDARY TO (R)

Hemidiaphragm Paralysis: (R) Mild Lobe Collapse: Chronic

Obstructive Pulmonary Disease: Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James P. G. Flynn MD

29c. License number

D01346

29d. Date signed (Month, Day, Year)

March 24 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES P. G. FLYNN MD DEATON SPECIALTY HOSPITAL 611 S. CHARLES ST 21230

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1917

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09037

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eldern Wesley

2. Date of Death

March 20 1997 1815 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

MERCY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

164-44-7140

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUG. 27, 1951

9. Birthplace (State or Foreign Country)

CHESTER, PA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2105 N. HILTON STREET

10f. Zip Code

21216

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

MASTERS DEGREE

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

PROGRAM DIRECTOR

16b. Kind of Business/Industry

YOUTH SERVICES

17. Father's Name (First, Middle, Last)

ELDERN W. WESLEY SR.

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN KELLY

19a. Informant's Name/Relationship (Type, Print)

EVELYN WESLEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

731 ENGLE STREET, CHESTER, PA 19013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LAWN CROFT CEMETERY 3-27-97 LINWOOD, PA.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.  
2140 N. FULTON AVE., BALTIMORE, MD. 2121723e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cirrhosis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 yr

b. AIDS

Due to (or as a consequence of):

8 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Scott Huber MD

29c. License number

PO 9738

29d. Date signed (Month, Day, Year)

March 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Scott Huber MD 301 St Paul Place Baltimore, MD 21202

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State  
Registrar





Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>DWAYNE BRUCE WHITE</b>				2. Date of Death Month <b>MARCH</b> Day <b>23</b> , Year <b>1997</b>		3. Time of Death <b>5:54 PM.</b>	
4a. Facility Name (If not institution, give street and number) <b>3801 BUTTERCUP RD.</b>				4b. City, Town, or Location of Death <b>SYKESVILLE</b>		4c. County of Death <b>UNKNOWN</b>	
5. Social Security Number <b>219-74-6004</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN, 9, 1960</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>750 W. HAMBURG STREET</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+ GRADE</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>WASTE DISPOSAL CO.</b>	
17. Father's Name (First, Middle, Last) <b>FRANKLIN WHITE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JEAN HARRELL</b>			
19a. Informant's Name/Relationship (Type, Print) <b>JEAN HARRELL (MOTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>750 W. HAMBURG ST., BALTIMORE, MD, 21230</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN STAR CEMETERY</b>		Date <b>3-28-97</b>		20c. Location - City or Town, State <b>CATONSVILLE, MD.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME, P. A. 2140 N. FULTON AVE., BALTIMORE, MD, 21217</b>			
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Ischaemic Heart Disease</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>IN JAIL</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (attach only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MARCH 24, 1997</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09039

Item: 26, per Physician G-745 3/26/97 reb *Certificate of Death*

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSLYN WINGERS</b>		2. Date of Death Month <b>MARCH</b> Day <b>13</b> Year <b>1997</b>		3. Time of Death <b>8:39 PM</b>
	4e. Facility Name (If not institution, give street and number) <b>FALLSTON GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>FALLSTON</b>		4c. County of Death <b>HARFORD</b>
Funeral Director	5. Social Security Number <b>087-12-3582</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>NOV. 28, 1921</b>		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>BEL AIR</b>
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>106 N. LYNBROOK ROAD</b>		
	10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MEDICAL CLAIMS CONSULTANT</b>		16b. Kind of Business/Industry <b>SOCIAL SECURITY ADMIN.</b>		
	17. Father's Name (First, Middle, Last) <b>JEROME WINGERS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LEAH FOX</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>ANNETTE S. RENARD / DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1824 HANSON ROAD EDGEWOOD, MD 21040</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>RIVERSIDE</b>		20c. Location - City or Town, State <b>3/16/97 ROCHELLE PARK, NJ</b>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. myocardial infarction</b> Due to (or as a consequence of): <b>b. coronary artery disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>sudden</b> <b>years</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes II type</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D20673</b>		29d. Date signed (Month, Day, Year) <b>3/14/97</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>5810 Belair Rd Bel Air, MD 21206</b>					
31. Date filed (Month, Day, Year) <b>MAR 26 1997</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per MEO G-746 4/1/97 <sup>reb</sup> Certificate of Death

Reg. No.

97 09040

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KEITH WAYNE AYERS</b>			2. Date of Death Month <b>MARCH</b> Day <b>20</b> Year <b>1997</b>		3. Time of Death <b>8:40AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>1621 SHUCKS ROAD</b>			4b. City, Town, or Location of Death <b>BELAIR</b>		4c. County of Death <b>HARFORD</b>		
Funeral Director	5. Social Security Number <b>220-74-4837</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>38</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 15, 1958</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1621 Shucks Road</b>		10f. Zip Code <b>21015</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Grounds Keeper</b>		16b. Kind of Business/Industry <b>Cemetery</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Aleck Ayers</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Jeanette Melba Moxley</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Joseph A. Ayers, father</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1621 Shucks Road, Bel Air, Maryland 21015</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Date <b>3/24/97</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ALCOHOL AND AMITRIPTYLINE INTOXICATION</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>found 3/20/97</b>		28b. Time of Injury <b>6:00 A.M.</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>at residence</b>		28d. Describe how injury occurred <b>Subject ingested pills</b>					
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1621 Shucks Rd. Baltimore, Md.</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MARCH 20, 1997</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>MAR 28 1997</b>			32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09041

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

URSULA

2. Date of Death

March 13 1997

Day

Year

3. Time of Death

0415

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

216-38-8153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/21/1941

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

SOMERSET

10c. City, Town or Location

MARION STATION

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

PHOENIX CHURCH ROAD

10f. Zip Code

21838

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HANDICAPPED

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

RICHARD S. POWELL

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA WEBSTER

19a. Informant's Name/Relationship (Type, Print)

MARTHA POWELL/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30370 MAPLE STREET, PRINCESS ANNE, MD. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ASBURY CEMETERY

Date

03/15/97

20c. Location - City or Town, State

MT. VERNON, MD.

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

HINMAN FUNERAL HOME

MO0295

11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Arrest  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End stage COPD  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P Cardiac arrest resulting in Anoxic encephalopathy

w/o Lung cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0050614

29d. Date signed (Month, Day, Year)

3/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LORRAINE TAYLOR M.D. 262 THYME RD SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Julia D. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09042

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN MAXINE ALLEN				2. Date of Death Month Day Year MARCH 12, 1997		3. Time of Death 12:50 P.M.	
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 214-07-4017 A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT) BER 2 1910	
	9. Birthplace (State or Foreign Country) MARYLAND							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 12017 WOOD ROSE AVE N.E.				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CELENASE CORP OF AMERICA		16b. Kind of Business/Industry SILK/MANUF.			
	17. Father's Name (First, Middle, Last) WILLIAM F. ALBRIGHT				18. Mother's Name (First, Middle, Maiden Surname) PEARL CHIDESTER			
	19a. Informant's Name/Relationship (Type, Print) GREG KIGHT P.R.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 GEPHART DRIVE APT#6 CUMBERLAND MARYLAND 21502			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) REST LAWN CEMETERY		Date MARCH 14 1997		20c. Location - City or Town, State LAVALLE MARYLAND	
	21. Signature of Funeral Service Licensee Dale L. Merritt				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION							Less than 48 hours	
Due to (or as a consequence of): b. PNEUMONIA							Less than 48 hours	
Due to (or as a consequence of): c. UROSEPSIS							Less than 48 hours	
Due to (or as a consequence of): d.								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Qamar M.D.				29c. License number D 23371		29d. Date signed (Month, Day, Year) March 12, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qamar Zaman M.D. Johnson Heights Medical Bldg. Cumberland, MD 21502								
31. Date filed (Month, Day, Year) MAR 13 1997								
32. Registrar's Signature John A. Randall								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

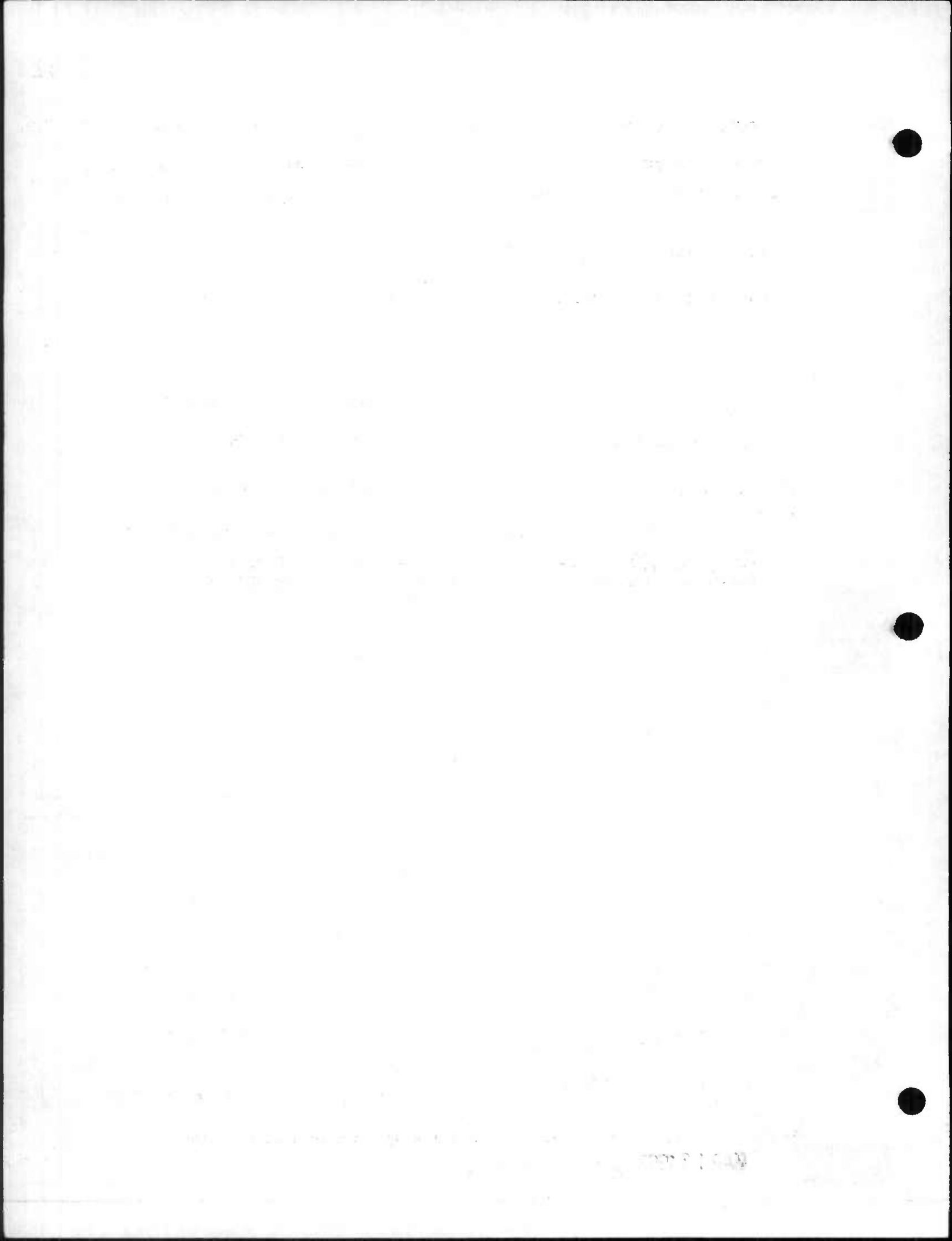
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09043

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma O. Allin

2. Date of Death

March 7, 1997

3. Time of Death

5:30PM

4a. Facility Name (If not institution, give street and number)

Manor Care-Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

217-48-6133

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 16, 1899

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5214 Goddard Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Otto Otteson

18. Mother's Name (First, Middle, Maiden Surname)

Antonette Olson

19a. Informant's Name/Relationship (Type, Print)

Thelma A. Dudrow / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5214 Goddard Road, Bethesda, Maryland 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

March 11, 1997

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

David E. Perry M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Approximate Interval Between Onset and Death

1 Week

Due to (or as a consequence of):

b. Obstruction Esophagus with Aspiration

6 months

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, Malnutrition due to Obstruction

Esophagus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James J. Foster, M.D.

29c. License number

D04179

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James J. Foster, M.D., 5530 Wisconsin Avenue, #925, Chevy Chase, MD 20815-4330

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09044

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID

EDMUND

ASHLEY

2. Date of Death

Month

Day

Year

March

5, 1997

3. Time of Death

3:25 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

118-01-6607

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

March

19,

1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7051 Carroll Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sign-Painter

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Frank B. Ashley

18. Mother's Name (First, Middle, Maiden Surname)

Edith Yates

19a. Informant's Name/Relationship (Type, Print)

Dean Ashley (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10803 Harvey Drive Apt. #10 Fairfax, Va. 22030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Comfort Crematory

Date

03/06/97

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Affordable Funeral Services

2230 Gallows Road Dunn Loring, Va. 22027

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Respiratory Failure

3 hours

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

15 years

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alfred Munzer M.D.

29c. License number

D12522

29d. Date signed (Month, Day, Year)

March 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alfred Munzer MD 7600 Carroll Avenue Takoma Park, MD 20912

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09045

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Abdulha Kim</i>		2. Date of Death Month <i>March</i> Day <i>12</i> Year <i>1997</i>		3. Time of Death <i>5:26pm</i>
	4a. Facility Name (If not institution, give street and number) <i>Prince George Hospital</i>		4b. City, Town, or Location of Death <i>Cheverly</i>		4c. County of Death <i>Prince George</i>
Funeral Director	5. Social Security Number <i>231-53-4597</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>33</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>Nov. 14, 1963</i>		9. Birthplace (State or Foreign Country) <i>Ethiopia</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <i>N.Y.</i>		10b. County <i>Monroe</i>
	10c. City, Town or Location <i>Rochester</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <i>P.O. Box 40824</i>		10f. Zip Code <i>14604</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i></i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>unemployed</i>
	16b. Kind of Business/Industry <i>N/A</i>		17. Father's Name (First, Middle, Last) <i>Abdela Abanuru</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Momina Getahun</i>
	19a. Informant's Name/Relationship (Type, Print) <i>Mohamed Abdela/brother</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7600 Fountain Blue Dr. #605 New Carrollton, MD 20784</i>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Washington National Cem.</i>		20c. Location - City or Town, State <i>Mar. 14 '97 Suitland, MD</i>
	21. Signature of Funeral Service Licensee <i>John F. DeVol</i>		22. Name and Address of Facility <i>DeVol Funeral Home 2222 Wisconsin Ave., NW Washington, D.C. 20007</i>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Respiratory Failure</i> Due to (or as a consequence of): <i>Metastatic Sarcoma</i> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death <i>1 day</i> <i>month</i>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>James Catavenis</i>		29c. License number <i>030318</i>	
29d. Date signed (Month, Day, Year) <i>3/13/97</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James Catavenis, M.D. 3001 Hospital Drive Cheverly, MD 20784</i>			
31. Date filed (Month, Day, Year) <i>MAR 14 1997</i>		32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar





97 09046

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY R ATKINS</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>9</b> YEAR <b>97</b>		3. TIME OF DEATH <b>12:02 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>236-18-7952</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>76</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12-18-1920</b>	8. BIRTHPLACE (State or Foreign Country) <b>WV</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Brevin Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Havre de Grace</b>		9c. COUNTY OF DEATH <b>Harford</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>n/a</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6312 Boston Street</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Barney McIntee</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Murray</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Bernard E. McIntee Brother</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1318 S. Tollgate Road, Bel Air, MD 21015</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co., Inc. 3/10</b>		20c. LOCATION — City or Town, State <b>West Chester, Pa.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Huntington's Disease</b>  Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>Head Only</b>  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Whitman MD</b>				29c. LICENSE NUMBER <b>D32609</b>		29d. DATE SIGNED (Month, Day, Year) <b>3/9/97</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kamradis Melina MD 703 Revolution St. Havre de Grace MD 21078</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 11 1997</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09047

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN IRENE ARNOLD</b>				2. Date of Death Month <b>March</b> Day <b>10</b> Year <b>1997</b>		3. Time of Death <b>3:45 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Northampton Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>220-03-9523</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 6, 1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>9539 Bartgis Road</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Clerk</b>				16b. Kind of Business/Industry <b>Retail Hardware</b>	
	17. Father's Name (First, Middle, Last) <b>ERNEST UTTERBACK</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GRACE FOGLE</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Richard H. Arnold, Sr. / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9539 Bartgis Rd. / Frederick, Maryland 21702</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		Data <b>3-14-97</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>Draymond Petersen</i>				22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>1621 Opossumtown Pike / Frederick, Md. 21702</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. <b>E.V.A.</b> a. <b>ASPIRATION PNEUMONIA</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>11/96</b> <b>2 wks</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE, Previous M.I. 11/96</b> <b>Hypertension</b>							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>James L. Hume M.D.</i>				29c. License number <b>D 21944</b>		29d. Date signed (Month, Day, Year) <b>3/10/97</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James L. Hume M.D.</i> <b>300 W. 9th Street, Frederick, Md. 21701</b>							
31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>				32. Registrar's Signature <i>James L. Hume</i>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09048

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES F. BOWERS, JR.</b>				2. Date of Death Month <b>March</b> Day <b>3</b> Year <b>1997</b>		3. Time of Death <b>12:35 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>232-26-3156</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 7, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>WV</b>		10b. County <b>MINERAL</b>		10c. City, Town or Location <b>KEYSER</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>ROUTE 2, BOX 196</b>		10f. Zip Code <b>26726</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BUS DRIVER</b>		16b. Kind of Business/Industry <b>MINERAL COUNTY BOARD OF EDUCATION</b>			
	17. Father's Name (First, Middle, Last) <b>J. FLOREN BOWERS, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CARRIE KEISTER</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JAMES H. BOWERS / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>ROUTE 2, BOX 196 - KEYSER, WV 26726</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FT. ASHBY CEMETERY</b>		Date <b>3/6/97</b>		20c. Location - City or Town, State <b>FT. ASHBY, WV</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, INC. P.O. BOX 1260 - FT. ASHBY, WV 26719</b>			
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Right cerebral infarction</b> Due to (or as a consequence of): <b>b. Abdominal aortic aneurysm</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>1 month</b> <b>6 weeks</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of Certifier 		29c. License number <b>D17456</b>		29d. Date signed (Month, Day, Year) <b>March 4 1997</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. P. Schroeder Memorial Hospital Cumberland, MD. 21502</b>				31. Date filed (Month, Day, Year) <b>MAR 06 1997</b>			
	32. Registrar's Signature 							




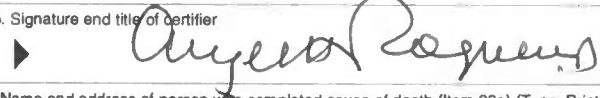
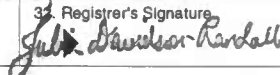
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09049

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Clinton Burton, Sr.</b>				2. Date of Death Month <b>MARCH</b> Day <b>6</b> Year <b>1997</b>				3. Time of Death <b>0258 A.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>			
Funeral Director	5. Social Security Number <b>225-28-7954</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08-Jan-25</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>			
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>				10b. County <b>Allegany</b>				10c. City, Town or Location <b>Frostburg</b>			
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>323 East Main Street</b>				10f. Zip Code <b>21532-</b>			
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>			
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>8</b>			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Professor of Economics</b>				16b. Kind of Business/Industry <b>Teaching</b>				17. Father's Name (First, Middle, Last) <b>George W. Burton</b>			
	18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth Vannah</b>				19a. Informant's Name/Relationship (Type, Print) <b>Sarah Burton Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>323 East Main Street Frostburg Maryland 21532-</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Conner Family Cemetery</b>				20c. Location - City or Town, State <b>09-Mar-97 New Bern, North Carolina</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>				23e. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>2 days</b> <b>15 years</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>M</b>				28b. Time of Injury <b>M</b>				
28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
29c. License number <b>D13166</b>				29d. Date signed (Month, Day, Year) <b>March 6, 1997</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Angel H. Rague MD, 48 Tarn Terrace Frostburg, MD 21532</b>				
31. Date filed (Month, Day, Year) <b>MAR 07 1997</b>				32. Registrar's Signature 				State Registrar				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 must be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09050

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PHILLIP HENRY BRIDGEWATER SR.

2. Date of Death

Month  
MARCH

Day

1 1997

3. Time of Death

2215 PM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

5. Social Security Number

245-24-3511

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Aug. 25, 1926

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

WV

10b. County

Hampshire

10c. City, Town or Location

Romney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

HC 63, Box 2580

10f. Zip Code

26757

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Optician

16b. Kind of Business/Industry

Eye Glasses

17. Father's Name (First, Middle, Last)

Jack Bridgewater

18. Mother's Name (First, Middle, Maiden Surname)

Leola Keaner

19a. Informant's Name/Relationship (Type, Print)

Phyllis L. Bagdonis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23929 Jockey Club. Ter., Damascus, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

Mar. 6 1997

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Shaffer Funeral Home, Inc.  
230 East Main St., Romney, WV 26757

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 years

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

SEIZURES, PNEUMONIA

ARTERIO - VENOUS MALFORMATION OF THE BRAIN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35135

29d. Date signed (Month, Day, Year)

MARCH 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS E. CHAPPELL M.D., 912 SETON DRIVE CUMBERLAND MD 21502

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09051

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <i>Lester BistLine</i>				2. Date of Death Month <i>March</i> Day <i>7</i> Year <i>1997</i>		3. Time of Death <i>10:52 P.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Memorial Hospital</i>				4b. City, Town, or Location of Death <i>Cumberland</i>		4c. County of Death <i>Allegheny</i>	
Funeral Director	5. Social Security Number <i>195-07-3916</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>82</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Aug. 22, 1914</i>	
	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>		10a. State <i>Penna.</i>		10b. County <i>Bedford</i>		10c. City, Town or Location <i>Hyndman</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>P.O. Box 707</i>		10f. Zip Code <i>15545</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Packer</i>		16b. Kind of Business/Industry <i>U.S. GOVERNMENT</i>			
	17. Father's Name (First, Middle, Last) <i>Bruce BistLine</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Edna Barrick</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Margaret BistLine/Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 707, Third Ave. Hyndman, Pa. 15545</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Fairview Bethel Cemetery</i>		20c. Location - City or Town, State <i>March 11, 1997 Fairview Twp. Penna</i>			
	21. Signature of Funeral Service Licensee <i>Eugene P. Nallin</i>				22. Name and Address of Facility <i>Leasure-Stein, Inc. 230 Baltimore Ave. Cumberland, Md. 21502</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Sudden Cardiac Death</i> Due to (or as a consequence of):  b. <i>Coronary Artery Disease</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death  <i>5 years</i>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Eugene P. Nallin</i>		29c. License number <i>D 34812</i>		29d. Date signed (Month, Day, Year) <i>March 8, 1997</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Eugene P. Nallin/Hyndman Health Center/Hyndman, Pa. 15545</i>							
State Registrar	31. Date filed (Month, Day, Year) <i>MAR 10 1997</i>		32. Registrar's Signature <i>Jane [Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09052

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN EDWARD BEAN

2. Date of Death

MARCH 21, 1997

3. Time of Death

09:00 AM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

215 26 2319

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT. 17, 1908

9. Birthplace (State or Foreign Country)

TENNESSEE

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

LAYTONSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21411 LAYTONSVILLE ROAD

10f. Zip Code

20882

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Navar Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LANDSCAPER

16b. Kind of Business/Industry

LANDSCAPING

17. Father's Name (First, Middle, Last)

COLUMBUS BEAN

18. Mother's Name (First, Middle, Maiden Surname)

MOLLIE ELKINS

19a. Informant's Name/Relationship (Type, Print)

BASCOM BEAN, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1678 ST. MICHAEL ROAD, WOODBINE, MD. 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAYTONSVILLE CEMETERY

Date

3/24/97

20c. Location - City or Town, State

LAYTONSVILLE, MD.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME  
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HYPOSTATIC PNEUMONITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

CHRONIC OBSTRUCTIVE LUNG DISEASE yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRAL THROMBOSIS - REMOTE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald R. Lewis MD

29c. License number

D06406

29d. Date signed (Month, Day, Year)

MARCH 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD R. LEWIS MD, RT108 OLNEY MD 20832

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 25 1997

32. Registrar's Signature

The Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09053

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Olive H. Bennett

2. Date of Death

Month Day Year  
March 10, 1997

3. Time of Death

12:00AM

4a. Facility Name (If not institution, give street and number)

Manor Care-Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

242-16-0914

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 18, 1918

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4600 Connecticut Avenue, N.W. #603

10f. Zip Code

20008

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Secretary

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

William Henderson Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Reid Matthews

19a. Informant's Name/Relationship (Type, Print)

Frances B. Bush/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1388 Seabreeze Street, Clearwater, Florida 34616

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)March 10, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael J. Grady, M.D. M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 Month

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael J. Grady

29c. License number

D38781

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael J. Grady, M.D. 4910 Massachusetts Avenue, N.W., Washington, D.C. 20016

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09054

Amended #19a, 3/10/97, JW, Montg. Cty.

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Poole Berry

2. Date of Death

Month Day Year  
March 5, 1997

3. Time of Death

6:15 PM

4e. Facility Name (If not institution, give street and number)

3555 Fiske Terrace

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-54-6951

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 10, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3555 Fiske Terrace

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas A. Poole

18. Mother's Name (First, Middle, Maiden Surname)

Beth Pruden

19e. Informant's Name/Relationship (Type, Print)

J. Kenyon Poole Berry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2917 Terrace Drive, Chevy Chase, MD 20815

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

3-6-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carola Delm

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

6 months

Due to (or as a consequence of):

b. Multi Infarct Dementia

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. Thakar, M.D.

29c. License number

D43430

29d. Date signed (Month, Day, Year)

March 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

18111 PRINCE PHILIP DR #212 OLNEY MD 20832

31. Date filed (Month, Day, Year)

MAR 07 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09055

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Leslie Braxton

2. Date of Death

March 6, 1997

3. Time of Death

10:36 PM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

226-24-4494

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 1, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1321 Kenyon Street, NW, #408

10f. Zip Code

20010

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

janitor

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Joanna Braxton

19e. Informant's Name/Relationship (Type, Print)

Joanna Sandidge / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 5, Box 241, Amherst, VA 24521

20e. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Jerusalem Baptist Church Cem 3-11-97 Amherst, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Ellen H. Rapp*

22. Name and Address of Facility

Winfree-Wright Funeral Service, Inc.  
P. O. Box 1635, Amherst, VA 24521

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Acute myocardial infarction*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*minutes*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dr. Alexander M.D.*

29c. License number

D09834

29d. Date signed (Month, Day, Year)

3/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GARRY ROSENBAUM 3720 FARRAGOT AVE. KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

*John Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



97 09056

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09057

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Campbell Brandalick				2. Date of Death Month Day Year March 8, 1997		3. Time of Death 8:50 AM	
	4a. Facility Name (If not institution, give street and number) Rockville Nursing Home				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 110-12-5304		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Jan 11, 1910	
	9. Birthplace (State or Foreign Country) Scotland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac	
To Be Completed by Funeral Director	10a. Street and Number 12305 Briarbush Lane		10f. Zip Code 20854		10g. Citizen of What Country? United States		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Dougald Campbell				18. Mother's Name (First, Middle, Maiden Surname) Marion Grant			
	19a. Informant's Name/Relationship (Type, Print) Judith Dubowy, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12305 Briarbush Lane, Potomac, Maryland 20854			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia		20d. Date Mar 17, 1997	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>CARDIOPULMONARY ARREST</b> Due to (or as a consequence of): b. <b>COLON CANCER</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  29c. License number D27830 29d. Date signed (Month, Day, Year) 3/10/97								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramleth T. Shaker, M.D., 9019 Shady Grove Court, Gaithersburg, MD 20877								
31. Date filed (Month, Day, Year) MAR 13 1997 32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09058

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cecilia H. Brooks

2. Date of Death

March 11, 1997

3. Time of Death

1:45 Pm

4a. Facility Name (If not institution, give street and number)

Hillhaven Nursing Center

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

120-18-3933

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 25, 1907

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10413 Rutland Place

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

(Unavailable) Stotchik

18. Mother's Name (First, Middle, Maiden Surname)

Helen Shapiro

19a. Informant's Name/Relationship (Type, Print)

Marna H. Wattenberg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

3-12-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration Pneumonia

24 hours

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Stroke

2 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles M. Benner MD

29c. License number

D31563

29d. Date signed (Month, Day, Year)

March 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES M BENNER MD

11251 Lockwood Drive  
Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09059

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsie S. Burgess</b>				2. Date of Death Month Day Year <b>March 8, 1997</b>		3. Time of Death <b>2:54am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wilson Health Care Center</b>				4b. City, Town, or Location of Death <b>Gaithersburg,</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>577-05-8008A</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 6, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>MOUNT RAINIER</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>403 Russell Ave.</b>		10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Federal Govt.</b>			
	17. Father's Name (First, Middle, Last) <b>Homer Stanforth</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Vallie C. Horner</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Bonnie F. Zager (Executrix)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9029 49th Place College Park, MD 20740</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>		20c. Location - City or Town, State <b>3-9-1997 Brentwood, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hines Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>sepsis</b> Due to (or as a consequence of): <b>hepatic C cirrhosis with portal hypertension 2074</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>osteoporosis</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>osteoporosis</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number <b>D19294</b>		29d. Date signed (Month, Day, Year) <b>March 8, 1997</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN R. MELNICK 911 Russell Ave. Gaithersburg Md 20879</b>								
31. Date filed (Month, Day, Year) <b>MAR 12 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per ME0 G-7464/1/97 re Certificate of Death

Reg. No.

97 09060

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES PEARSON BURNETT</b>				2. Date of Death Month <b>MARCH</b> Day <b>10</b> Year <b>1997</b>		3. Time of Death <b>2122</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>TAKOMA PARK</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>214-36-4221</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 17, 1938</b>	
	9. Birthplace (State or Foreign Country) <b>Illinois</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Takoma Park</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>8515 Hood Street</b>		10f. Zip Code <b>20912</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>Health Care</b>			
	17. Father's Name (First, Middle, Last) <b>Frank Gordon Pearson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Evalyn J. Simpson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Edwin D. Burnett/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8515 Hood St. Takoma Park, MD 20912</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		Date <b>Mar 14, 1997</b>		20c. Location - City or Town, State <b>Brentwood, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MULTI-DRUG INTOXICATION</b> <b>[ MORPHINE, METHADONE, DIPHENHYDRAMINE, CHLORPHENIRAMINE, AMITRIPTYLINE ]</b>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found 3/10/97</b>		28b. Time of Injury <b>9:05</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred <b>Unknown</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Found at home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8515 Hood St. Takoma Park, Md.</b>			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MARCH 11, 1997</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09061

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel May Bennett

2. Date of Death

March 10, 1997

3. Time of Death

12:10pm

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

272-22-7806

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 27, 1902

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Monrovia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12206 Fingerboard Road

10f. Zip Code

21770

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ira O. May

18. Mother's Name (First, Middle, Maiden Surname)

Susan Gartrell

19a. Informant's Name/Relationship (Type, Print)

Louise B. Lachman/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12206 Fingerboard Rd. Monrovia Maryland 21770

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery Crematorium Inc 3/12

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Olin L. Molesworth P.A. Funeral Home

26401 Ridge Road Damascus, Maryland 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Atherosclerotic Heart Disease 3/11/97

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

2 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16428

29d. Date signed (Month, Day, Year)

3/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline III M.D. 300 West 9th Street, Frederick Maryland

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

Page 1 of 1

2

3

Page 1 of 1

Page 1 of 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09062

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard Ernest BOWEN

2. Date of Death

March

Day

9, 1997

3. Time of Death

11:50 A.M.

4a. Facility Name (If not institution, give street and number)

3602-A Green Valley Road

4b. City, Town, or Location of Death

Ijamsville

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

220-16-5014

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 16, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Ijamsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3602-A Green Valley Road

10f. Zip Code

21754

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personnel Administrator

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

Eldridge Clarence BOWEN

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Virginia MONTGOMERY

19a. Informant's Name/Relationship (Type, Print)

Velma B. Costolo, Mate

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 63, Monrovia, MD 21770

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory, March 11, 1997

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Allan H Ruby 00703

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home  
106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Renal Cell Cancer

Approximate Interval Between Onset and Death

One month

Due to (or as a consequence of):

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey Drobis

29c. License number

D18137

29d. Date signed (Month, Day, Year)

March 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Jeffrey Drobis, M.D., 12201 Plum Orchard Drive, Silver Spring, MD 20904

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Nuclear Radcliffe

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09063

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Elizabeth Mae Kelbaugh Bowers</i>				2. Date of Death Month <i>March</i> Day <i>4</i> Year <i>1997</i>		3. Time of Death <i>5:30 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>704 Weverton Road</i>				4b. City, Town, or Location of Death <i>Knoxville</i>		4c. County of Death <i>Washington</i>		
Funeral Director	5. Social Security Number <i>217-28-6830</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>67</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Feb 3 1930</i>	9. Birthplace (State or Foreign Country) <i>Yannowsburg MD</i>	
	Usual Residence of Decedent								
10a. State <i>VA</i>		10b. County <i>Loudoun</i>		10c. City, Town or Location <i>Puncheonville</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number <i>11332 Russell Road</i>				10f. Zip Code <i>20132</i>		10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Waitress</i>		16b. Kind of Business/Industry <i>Eckerd's Pharmacy</i>			
17. Father's Name (First, Middle, Last) <i>George M. Kelbaugh</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Anna M. Coulter</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Karen Baker (Daughter-in-law)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11332 Russell Rd Puncheonville VA 20132</i>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Old Brethren Cemetery 317</i>		Date <i>Brownsville MD</i>		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <i>Barbara A. Williams, Owner</i>				22. Name and Address of Facility <i>John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. apparent myocardial infarction</i> Due to (or as a consequence of): <i>ASCVD.</i>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b.</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>								Approximate Interval Between Onset and Death <i>immediate</i> <i>years</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>W. K. Williams</i>		29c. License number <i>016675</i>		29d. Date signed (Month, Day, Year) <i>3/4/97</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>W. K. Williams</i> <i>Brunswick MD 21716</i>									
31. Date filed (Month, Day, Year) <i>MAR 11 1997</i>		32. Registrar's Signature <i>Michael R. Smith</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09065

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Luther Melancthon BEARD

2. Date of Death

March 2, 1997 Year

3. Time of Death

11:55 AM

4a. Facility Name (If not institution, give street and number)

9503 Bethel Road

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

217-16-2070

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

May 4, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9503 Bethel Road

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1946-1949

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Core Worker

16b. Kind of Business/Industry

Steel Foundry

17. Father's Name (First, Middle, Last)

Reverdy Harrison BEARD

18. Mother's Name (First, Middle, Maiden Surname)

Mary Viola BOWERSOX

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary Beard, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9503 Bethel Road, Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Pauls Lutheran Cemetery, March 5, 1997 Uniontown, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard E. Gray

M00255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home  
106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Adenocarcinoma of Stomach

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Biliary Obstruction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward F. Fisher MD

29c. License number

D 36610

29d. Date signed (Month, Day, Year)

March 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Edward F. Fisher MD 56 Thomas Johnson Drive, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

MAR 05 1997

32. Registrar's Signature

John A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Amended 3/7/97 line 6. Starrell FCHD

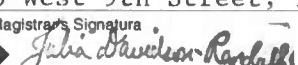
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09064

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLOTTE E BURRIER</b>				2. Date of Death Month <b>March</b> Day <b>2</b> Year <b>1997</b>		3. Time of Death <b>9:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Health Care Center</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>213-38-5833</b> <del>213-38-5883</del>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1001 Carroll Parkway Apt. 410</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Eader</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Rager</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ruth McKinney / niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7991 Clipper Ct., Frederick, Maryland 21701</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>		20d. Date <b>3/5/97</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atherosclerotic Heart Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D16428</b>		29d. Date signed (Month, Day, Year) <b>3/3/97</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Casper Cline, M.D. 300 West 9th Street, Frederick, MD</b>								
31. Date filed (Month, Day, Year) <b>MAR 05 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09066

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Eldridge Barnes</b>		2. Date of Death Month <b>March</b> Day <b>12</b> Year <b>1997</b>		3. Time of Death <b>3:15PM</b>
	4a. Facility Name (If not institution, give street and number) <b>The Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>
Funeral Director	5. Social Security Number <b>214-42-7715</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sept. 17 1944</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>Dorchester</b>	10c. City, Town or Location <b>Hurlock</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>103 Andrews St.</b>		10f. Zip Code <b>21643</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Labor Market Analyst</b>		16b. Kind of Business/Industry <b>State of Maryland</b>		
	17. Father's Name (First, Middle, Last) <b>Vernon Augustus Barnes</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Lorraine Busta</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Merry L. Webb - sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1535 Deep Point Rd. Woolford MD 21677</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery 3-17</b>		20c. Location - City or Town, State <b>Hurlock, Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Non-small Cell Lung Cancer</b>				Approximate Interval Between Onset and Death <b>1 mo.</b>
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 					
29c. License number <b>D39887</b>					
29d. Date signed (Month, Day, Year) <b>3/13/97</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David H. Smith, MD 509 Idlewild Ave. Easton MD 21601</b>					
31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09067

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence Mae Bell				2. Date of Death Month Day Year March 11, 1997		3. Time of Death 1:00 p.m.																																
	4a. Facility Name (If not institution, give street and number) 4881 Centennial Road				4b. City, Town, or Location of Death Vienna		4c. County of Death Dorchester																																
Funeral Director	5. Social Security Number 213-22-6037		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 08/20/25																																
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Dorchester		10c. City, Town or Location Vienna																																
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4881 Centennial Road		10f. Zip Code 21869		10g. Citizen of What Country? United States																																
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Canning House Worker		16b. Kind of Business/Industry Food Processing																																		
	17. Father's Name (First, Middle, Last) Clarence Johnson				18. Mother's Name (First, Middle, Maiden Surname) Katie Henry																																		
	19a. Informant's Name/Relationship (Type, Print) Lucille Henry				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4881 Centennial Road, Vienna, MD 21869																																		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Unity-Washington Cem		20c. Date 3/15		20d. Location - City or Town, State Hurlock, Maryland																																
	21. Signature of Funeral Service Licensee Michael F. Eskow				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632																																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Severe Dementia</u></td> <td rowspan="4">Approximate Interval Between Onset and Death 5 yrs 3 yrs</td> </tr> <tr> <td>b. <u>Colon Cancer</u></td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Severe Dementia</u>	Approximate Interval Between Onset and Death 5 yrs 3 yrs	b. <u>Colon Cancer</u>	c. _____	d. _____																									
	Immediate Cause (Final disease or condition resulting in death)	a. <u>Severe Dementia</u>	Approximate Interval Between Onset and Death 5 yrs 3 yrs																																				
b. <u>Colon Cancer</u>																																							
c. _____																																							
d. _____																																							
<table border="1"> <tr> <td colspan="2">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="2">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																					
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="6">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																					
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		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																																			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																							
29b. Signature and title of certifier Michael F. Eskow				29c. License number D26384		29d. Date signed (Month, Day, Year) 03-18-1997																																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael F. Eskow MD 302 Collins Hurlock Md. 21643																																							
31. Date filed (Month, Day, Year) MAR 18 1997		32. Registrar's Signature John Andrew Randall																																					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Amended #12, NRS  
3/18/97, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09068

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT W. CAGE</b>		2. Date of Death Month <b>March</b> Day <b>6</b> Year <b>1997</b>		3. Time of Death <b>4:10 pm</b>
	4e. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>
Funeral Director	5. Social Security Number <b>220-16-5857</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year <b>Oct 24, 1926</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>Allegany</b>	10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>504 West Industrial Blvd</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Machinist</b>		16b. Kind of Business/Industry <b>CSX Railroad</b>		
	17. Father's Name (First, Middle, Last) <b>John M. Cage</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Norine (Oglebay)</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Susan Sanders-step daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1 Box 49A1 Terra Alta WV 26764</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Restlawn Memorial Gardens</b>		20c. Location - City or Town, State <b>03/10 LaVale, MD</b>
	21. Signature of Funeral Service Licensee <b>James J. Scarpelli</b>		22. Name and Address of Facility <b>Scarpelli Funeral Home Cumberland, MD 21502</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic colon carcinoma</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>5 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>Dr. S. Gupta</b>		29c. License number <b>D 33280</b>		29d. Date signed (Month, Day, Year) <b>March 10, 1997</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. S. Gupta, Johnson Heights Medical Bldg., Cumberland, MD 21502</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>MAR 10 1997</b>		32. Registrar's Signature <b>John Davidson-Hardall</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1942

1942 1943 1944 1945

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1973 1974 1975 1976

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09069

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICK GARY COOPER				2. Date of Death Month Day Year MARCH 4, 1997		3. Time of Death 0947 AM		
	4a. Facility Name (If not institution, give street and number) MARYLAND ROUTE#135 - WAREHOUSE				4b. City, Town, or Location of Death McCOOLE		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 235-74-2086		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Feb 13 1946		
	9. Birthplace (State or Foreign Country) Maryland		10a. State WV		10b. County Mineral		10c. City, Town or Location Burlington		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number Rt 1, Box 19 B		10f. Zip Code 26710		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Winder Operator		16b. Kind of Business/Industry Paper Manufacturing				
	17. Father's Name (First, Middle, Last) Garland P. Cooper				18. Mother's Name (First, Middle, Maiden Surname) Elaine Hoffa				
	19a. Informant's Name/Relationship (Type, Print) Charlene June Cooper				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 1, Box 19 B Burlington, WV 26710				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) The Cumberland Crematory		Date Mar 9 1997		20c. Location - City or Town, State Cumberland, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. MULTIPLE INJURIES Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? XX Yes 2 <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	25. Was case referred to medical examiner? XX Yes 2 <input type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) WAREHOUSE								
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 3-4-1997		28b. Time of Injury 0842A M		28c. Injury at Work? XX Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred COMPRESSED IN A PAPER WINDER
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) WAREHOUSE									
28f. Location (Street and Number or Rural Route Number, City or Town, State) MD. RT. 135, McCOOLE, MARYLAND									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) MARCH 5, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAR 10 1997				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09070

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY DELORES CHAPMAN

2. Date of Death

MARCH

5 1997

3. Time of Death

8:20 AM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

215 26 9723

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JULY 30, 1930

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19710 SHAFT ROAD, SW

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JAMES O. TRULY

18. Mother's Name (First, Middle, Maiden Surname)

THELMA E. DAWSON

19a. Informant's Name/Relationship (Type, Print)

F. DALE CHAPMAN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19710 SHAFT ROAD, SW, FROSTBURG, MD 21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FROSTBURG MEMORIAL PARK 3/7/97

Data

20c. Location - City or Town, State

FROSTBURG, MD 21532

21. Signature of Funeral Service Licensee

Maribou M. Sowers

22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.

60 W. MAIN ST., FROSTBURG, MD 21532

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Adenocarcinoma of the right lung

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 months

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

J. E. Chapman MD

29c. License number

D35135

29d. Date signed (Month, Day, Year)

MARCH 6 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas E. van Chappell MD

912 Seton Dr Cumberland MD

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

John P. ...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97-1183-031

CIP

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State of Maryland / Department of Health and Mental Hygiene

97 09071

Items: 23 part I, 27, 28a-f per MEO G-746 4/1/97

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AMELIA C. CARTER</b>		2. Date of Death Month <b>MARCH</b> Day <b>7</b> Year <b>1997</b>		3. Time of Death <b>1:10AM</b>
	4a. Facility Name (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>		4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>577-34-8493</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Nov. 10, 1906</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Chevy Chase</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>8100 Connecticut Avenue, #1201</b>		10f. Zip Code <b>20816</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrator</b>		16b. Kind of Business/Industry <b>Hospital</b>		
	17. Father's Name (First, Middle, Last) <b>Fred L. Schultheiss</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Nittler</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Walter C. Pennington/ Great Nephew</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3808 Taylor Street, Chevy Chase, Maryland 20815</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>
	21. Signature of Funeral Service Licensee <b>Nichole G. Kutta</b> M00348		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>INTRACEREBRAL HEMORRHAGE</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>3/6/97</b>		
	28b. Time of Injury <b>3:44 P. M.</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28d. Describe how Injury occurred <b>driver in auto/auto collision</b>		
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>EAST WEST HIGHWAY &amp; CONNECTICUT AVE., MONTGOMERY CO., MD.</b>				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier <b>Nichole G. Kutta</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MARCH 7, 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>		32. Registrar Signature <b>Julia Davidson-Randall</b>			



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State of Maryland / Department of Health and Mental Hygiene

97 09072

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Campbell, Jr.

2. Date of Death

March 6, 1997

3. Time of Death

9:00 P.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

203 Williamsburg Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

214-10-7582

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 31, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

203 Williamsburg Drive

10f. Zip Code

20901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Tire

17. Father's Name (First, Middle, Last)

Frank Campbell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Riggs

19a. Intomant's Name/Relationship (Type, Print)

Anne Lenore Campbell/ Wife

19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code)

203 Williamsburg Drive, Silver Spring, Maryland 20901

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

March 8, 1997

Montgomery Crematorium, Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc., 300 W. Montgomery Avenue,

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cancer of the Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George F. Sengstack M.D.

29c. License number

D12121

29d. Date signed (Month, Day, Year)

March 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George F. Sengstack, M.D., 3929 Ferrara Drive, Wheaton, Maryland 20906

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Lisa Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT PAUL CLAYTON</b>				2. Date of Death Month <b>MARCH</b> Day <b>6</b> Year <b>1997</b>		3. Time of Death <b>6:30AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVER SPRINGS</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>554-81-8557</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb. 17, 1938</b>	9. Birthplace (State or Foreign Country) <b>Canada</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Kensington</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>10726 St. Paul Street</b>			10f. Zip Code <b>20895</b>		10g. Citizen of What Country? <b>Canada</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secondary Education</b>		16b. Kind of Business/Industry <b>Education</b>			
	17. Father's Name (First, Middle, Last) <b>Alfred Clayton</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Genevieve Paul</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Lima J. Clayton</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10726 St. Paul Street Kensington, Maryland 20895</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Date <b>3/10/97</b>	20c. Location - City or Town, State <b>Alexandria, Virginia</b>		
	21. Signature of Funeral Service Licensee <b>Kevin Gutowski</b>		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Theodore H. King</b>						
29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MARCH 6, 1997</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE H. KING 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>		32. Registrar's Signature <b>Johanna Davidson-Randall</b>						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 1, 3/10/97, JW, Montg. Cty.

Certificate of Death

Reg. No.

97 09074

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alessandro  
ALESSANDRO

SANTI

CRISAFULLI

2. Date of Death

Month Day Year

MARCH 1 1997

3. Time of Death

3:00P.M.

4a. Facility Name (If not institution, give street and number)

NEW HAMPSHIRE AVE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-44-9691

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 21, 1907

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2813 Blazer Court

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

University Professor

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Mario Crisafulli

18. Mother's Name (First, Middle, Maiden Surname)

Maria Bongiorno

19a. Informant's Name/Relationship (Type, Print)

Donald M. Crisafulli

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14613 Pebblestone Drive Silver Spring, Maryland

20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

3/06/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Eric S. Scurto

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

SCENE

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

3-1-97

28b. Time of Injury

1446

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver in auto accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

New Hampshire Ave @ Jefferson ST

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David L. Leland

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. LARON LOCKE, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

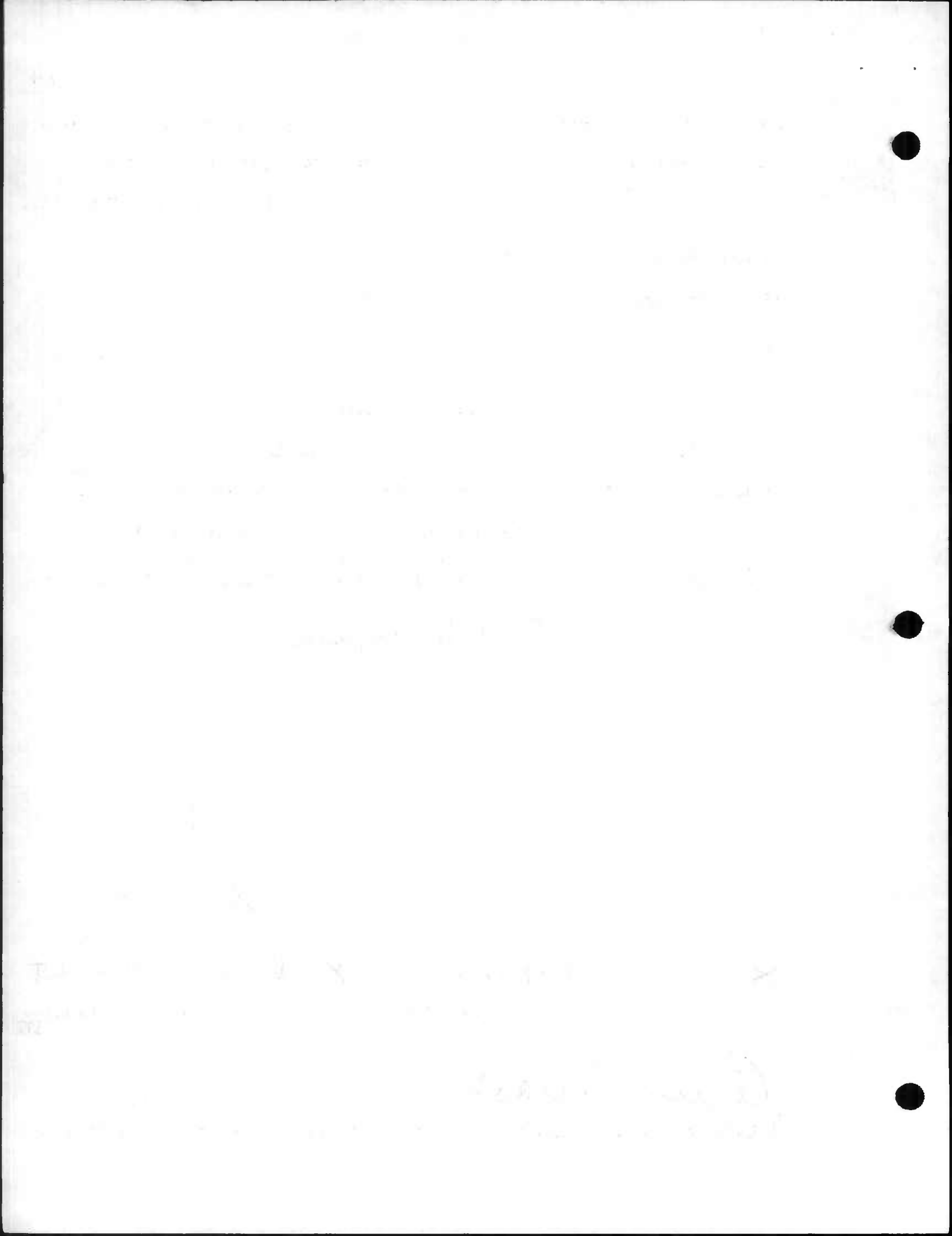
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09075

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE ROBERT COOPER</b>				2. Date of Death Month <b>March</b> Day <b>10</b> Year <b>1997</b>		3. Time of Death <b>2222</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>218-16-0608</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 2, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>18 Moore Drive</b>		10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>7th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Construction</b>			
	17. Father's Name (First, Middle, Last) <b>Robert Cooper</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florence M. Carroll</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Lucille Budd (Friend)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20906 12100 Bluehill Rd., Silver Spring, MD</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lincoln Park Cemetery 3/13</b>		20c. Location - City or Town, State <b>Rockville, MD</b>			
	21. Signature of Funeral Service Licensee <i>George H. Snowden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. <b>Congestive Heart Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):</p> <p>c. <b>Cardiomyopathy</b> Due to (or as a consequence of):</p> <p>d.</p> </div> </div>							
	23b. Approximate Interval Between Onset and Death <b>3 years</b>							
	23c. Approximate Interval Between Onset and Death <b>10 years</b>							
23d. Approximate Interval Between Onset and Death <b>5 years</b>								

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Pankaj Lal MD</i>		29c. License number <b>D39671</b>		29d. Date signed (Month, Day, Year) <b>MARCH 12 1997</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PANKAJ LAL 1111A ROCKVILLE PIKE SUITE 100 ROCKVILLE</b>							
31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>				32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09076

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward M. Cunningham				2. Date of Death Month 3 Day 11 Year 97		3. Time of Death 8:27 PM	
	4e. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 075-18-5244		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 25, 1925	
	9. Birthplace (State or Foreign Country) New York, NY		10e. State MD		10b. County Montgomery		10c. City, Town or Location Wheaton	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10f. Zip Code 20902		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer	
	16b. Kind of Business/Industry Washington, DC				17. Father's Name (First, Middle, Last) Michael B. Cunningham		18. Mother's Name (First, Middle, Maiden Surname) Jane E. Cryan	
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sylvia C. Cunningham				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Arvin Street, Wheaton, MD 20902			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham MD Vets		20c. Location - City or Town, State 3/17/97 Cheltenham, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Robert E. Ramsey				22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma pancreas Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate interval between Onset and Death 1 yr			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day Year)		28b. Time of injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D12121			
	29b. Signature and title of certifier George P. Sengstock MD				29d. Date signed (Month, Day, Year) 3-12-97			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) George Sengstock, MD 3929 Ferrara Drive, Wheaton, MD 20906				31. Data filed (Month, Day, Year) MAR 14 1997			
	32. Registrar's Signature Jana Davidson-Randall				33. Registrar's Title Registrar			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

10+1



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State of Maryland / Department of Health and Mental Hygiene

97 09077

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE STANLEY CHURN				2. Date of Death Month Day Year March 11 1997				3. Time of Death 11:33 PM	
	4a. Facility Name (If not institution, give street and number) 1627 Singer Road				4b. City, Town, or Location of Death Joppa				4c. County of Death Harford	
Funeral Director	5. Social Security Number 213-40-1717		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) April 9, 1939		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Joppa				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1627 Singer Road				10f. Zip Code 21085		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker			16b. Kind of Business/Industry Steel		
	17. Father's Name (First, Middle, Last) Frank (NMN) Churn				18. Mother's Name (First, Middle, Maiden Surname) Stephanie Julie Lepkowski					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jean C. Churn / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1627 Singer Road, Joppa, MD 21085					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris Co., Inc.		Date 3-13-97		20c. Location - City or Town, State West Chester, PA			
	21. Signature of Funeral Service Licensed 				22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>Pancreatic Cancer</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 9 months									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D46515		29d. Date signed (Month, Day, Year) MARCH 12th 1997			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solely, Johns Hopkins Oncology Center, 600 N Wolfe St Baltimore MD.									
	31. Date filed (Month, Day, Year) MAR 12 1997									





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 09078

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marcella Mitchell Cooper				2. Date of Death Month Day Year March 13 1997		3. Time of Death 6:55 A.M.	
	4a. Facility Name (If not institution, give street and number) 2629 West Medical Hall Rd.				4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford	
Funeral Director	5. Social Security Number 218-84-1319		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 12, 1925	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2629 West Medical Hall Rd.		10f. Zip Code 21015	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			
	16b. Kind of Business/Industry Own Home				17. Father's Name (First, Middle, Last) Bertram Dixon Swain			
	18. Mother's Name (First, Middle, Maiden Surname) Marcella Mitchell Davidson				19a. Informant's Name/Relationship (Type, Print) John R. Cooper - Husband			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2629 West Medical Hall Rd., Bel Air, MD 21015				20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
	20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co.				20c. Location - City or Town, State 3-15-97 W. Chester, Pa.			
	21. Signature of Funeral Service Licensee <i>Howard K. McComas III</i>				22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009			
	23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Melanoma c metastases</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>William H. B. Howard</i>				
29c. License number 09071				29d. Date signed (Month, Day, Year) March 13, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. B. Howard 201 E. University Pkwy, Baltimore, MD 21218				31. Data filed (Month, Day, Year) MAR 14 1997				
32. Registrar's Signature <i>John Davidson Randall</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09079

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM WALLACE DAVIS</b>		2. Date of Death Month <b>March</b> Day <b>11</b> Year <b>1997</b>		3. Time of Death <b>1015</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>195-05-7736</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>FEB. 3, 1913</b>		9. Birthplace (State or Foreign Country) <b>DELAWARE</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10a. State <b>MARYLAND</b>	10b. County <b>SOMERSET</b>	<b>WESTOVER</b>		
	10e. Street and Number <b>PO BOX 98</b>		10f. Zip Code <b>21871</b>		10g. Citizen of What Country? <b>U.S.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>WELDER</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>WELDER</b>		16b. Kind of Business/Industry <b>STEEL</b>
	17. Father's Name (First, Middle, Last) <b>HOWARD DAVIS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARTHA DAVIS</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>DEBORAH ADAMS/DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3524 ROGERS AVE., AUSTIN, PA. 19014</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BEECHWOOD CEMETERY</b>		Date <b>3/15/97</b>
	20c. Location - City or Town, State <b>PRINCESS ANNE, MD.</b>				
21. Signature of Funeral Service Licensee <i>James L. Davis</i>		22. Name and Address of Facility <b>HINMAN FUNERAL HOME 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853</b>			
Physician /Medical Examiner	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) <b>Sudden cardiac death</b>				
	Due to (or as a consequence of): <b>coronary artery disease</b>				
	Due to (or as a consequence of): <b>atrial fibrillation</b>				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>John McLean</i>		29c. License number <b>D25209</b>		29d. Date signed (Month, Day, Year) <b>3-11-97</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John McLean M.D. 106 MILFORD ST. SALISBURY MD 21801</b>					
31. Date filed (Month, Day, Year) <b>MAR 13 1997</b>		32. Registrar's Signature <i>John McLean</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09080

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID DANSON

2. Date of Death

March Day Year  
11 1997

3. Time of Death

12:50 AM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

149-10-3399

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 8, 1916

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3706 DULWICK DRIVE

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SYSTEMS ANALYST

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

ALEX DANSON

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIE ASSINOVSKY

19a. Informant's Name/Relationship (Type, Print)

ROBERT DANSON / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2102 BASSET ST., ALEXANDRIA, VA 22304

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

3/12

20c. Location - City or Town, State

OLNEY, MD

21. Signature of Funeral Service Licensee

DANIEL SIMONS

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.  
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PARKINSONISM - DEMENTIA COMPLEX

Approximate Interval Between Onset and Death

5 YEARS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

D. D. Patel, M.D. Attending Physician

29c. License number

D 18084

29d. Date signed (Month, Day, Year)

MARCH 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. D. PATEL, M.D. 6121 Montrose Rd, Rockville, MD 20852

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09081

Reg. No.

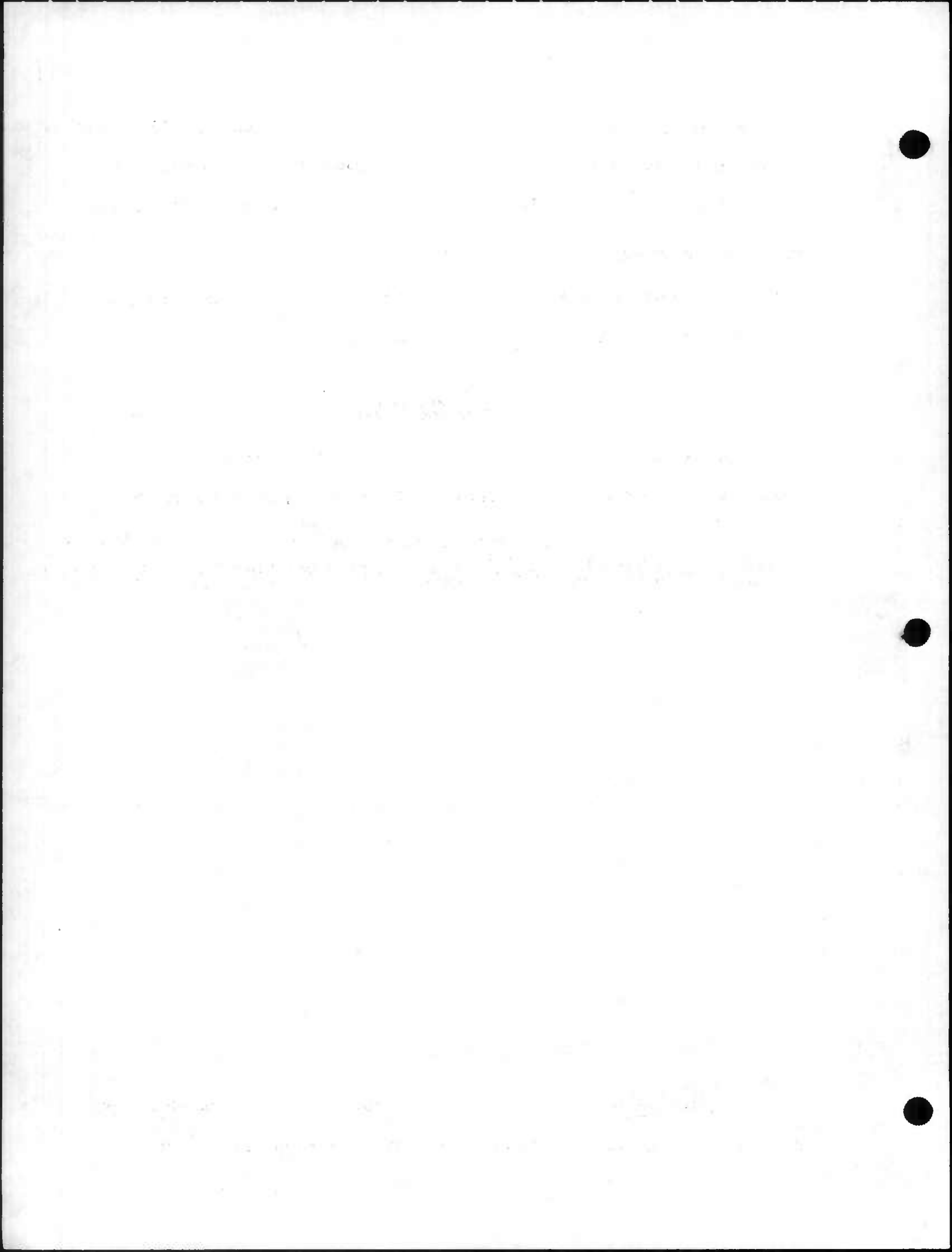
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mervin E. Dullum				2. Date of Death Month Day Year March 12, 1997		3. Time of Death 10:15 AM	
	4a. Facility Name (If not institution, give street and number) 10009 Meyer Point Terrace				4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 542-18-8313		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) August 23, 1922	
	9. Birthplace (State or Foreign Country) Oregon		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 10009 Meyer Point Terrace		10f. Zip Code 20854		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice President Government Affairs		16b. Kind of Business/Industry Airlines			
	17. Father's Name (First, Middle, Last) Elmer Ray Dullum				18. Mother's Name (First, Middle, Maiden Surname) Kathryn Nerness			
	19a. Informant's Name/Relationship (Type, Print) David A.R. Dullum / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Great Falls Street, Falls Church, VA 22046			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date March 14, 1997		20c. Location - City or Town, State Bethesda, Maryland	
	21. Signature of Funeral Service Licensee <i>Robert A. Pumphrey</i> M00831				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediata Cause (Final disease or condition resulting in death)</p> <p>a. Heart Failure</p> <p>Due to (or as a consequence of):</p> <p>b. Cardiomyopathy</p> <p>Due to (or as a consequence of):</p> <p>c. Endocarditis</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>Sequitely list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Chronic Renal Failure						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Richard H. Cooke</i>		29c. License number 15122		29d. Date signed (Month, Day, Year) March 12, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard H. Cooke, M.D. 110 Irving Street, NW Washington, D.C. 20010								
31. Date filed (Month, Day, Year) MAR 14 1997		32. Registrar's Signature <i>Julia Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rev 6/95







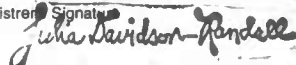
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09082

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Douglas Desmit</b>				2. Date of Death Month <b>March</b> Day <b>11</b> , Year <b>1997</b>		3. Time of Death <b>5:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>365-28-4957</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 1, 1928</b>		9. Birthplace (State or Foreign Country) <b>Florida</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Poolesville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>2900 W. Offutt Rd.</b>			10f. Zip Code <b>20873</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>-----</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Draftsman</b>		16b. Kind of Business/Industry <b>Kettler Brothers</b>			
	17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Suzanne Lord (Guardian of Person)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HHS 5630 Fishers Lane Rockville, MD. 20852</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chambers Crematory</b>		Date <b>3/13</b>		20c. Location - City or Town, State <b>Riverdale, MD.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, MD. 20737</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardio-Respiratory Arrest</b> Due to (or as a consequence of): <b>b. Septic Shock</b> Due to (or as a consequence of): <b>c. Pancytopenia</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death <b>Minutes</b> <b>5 Days</b> <b>5 Days</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diffuse Lymphoma</b> <b>Lymphomatous Meningitis</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD.		29c. License number <b>D43358</b>		29d. Date signed (Month, Day, Year) <b>March 11, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Grace E. Sagayadan, M.D. 849-C Quince Orchard Blvd. Gaithersburg, MD. 20878</b>								
31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>		32. Registrar's Signature 						

2.1.23 1.2.24 1.3.25 1.4.26 1.5.27 1.6.28 1.7.29 1.8.30 1.9.31 1.10.32 1.11.33 1.12.34 1.1.35 1.2.36 1.3.37 1.4.38 1.5.39 1.6.40 1.7.41 1.8.42 1.9.43 1.10.44 1.11.45 1.12.46 1.1.47 1.2.48 1.3.49 1.4.50 1.5.51 1.6.52 1.7.53 1.8.54 1.9.55 1.10.56 1.11.57 1.12.58 1.1.59 1.2.60 1.3.61 1.4.62 1.5.63 1.6.64 1.7.65 1.8.66 1.9.67 1.10.68 1.11.69 1.12.70 1.1.71 1.2.72 1.3.73 1.4.74 1.5.75 1.6.76 1.7.77 1.8.78 1.9.79 1.10.80 1.11.81 1.12.82 1.1.83 1.2.84 1.3.85 1.4.86 1.5.87 1.6.88 1.7.89 1.8.90 1.9.91 1.10.92 1.11.93 1.12.94 1.1.95 1.2.96 1.3.97 1.4.98 1.5.99 1.6.100 1.7.101 1.8.102 1.9.103 1.10.104 1.11.105 1.12.106 1.1.107 1.2.108 1.3.109 1.4.110 1.5.111 1.6.112 1.7.113 1.8.114 1.9.115 1.10.116 1.11.117 1.12.118 1.1.119 1.2.120 1.3.121 1.4.122 1.5.123 1.6.124 1.7.125 1.8.126 1.9.127 1.10.128 1.11.129 1.12.130 1.1.131 1.2.132 1.3.133 1.4.134 1.5.135 1.6.136 1.7.137 1.8.138 1.9.139 1.10.140 1.11.141 1.12.142 1.1.143 1.2.144 1.3.145 1.4.146 1.5.147 1.6.148 1.7.149 1.8.150 1.9.151 1.10.152 1.11.153 1.12.154 1.1.155 1.2.156 1.3.157 1.4.158 1.5.159 1.6.160 1.7.161 1.8.162 1.9.163 1.10.164 1.11.165 1.12.166 1.1.167 1.2.168 1.3.169 1.4.170 1.5.171 1.6.172 1.7.173 1.8.174 1.9.175 1.10.176 1.11.177 1.12.178 1.1.179 1.2.180 1.3.181 1.4.182 1.5.183 1.6.184 1.7.185 1.8.186 1.9.187 1.10.188 1.11.189 1.12.190 1.1.191 1.2.192 1.3.193 1.4.194 1.5.195 1.6.196 1.7.197 1.8.198 1.9.199 1.10.200 1.11.201 1.12.202 1.1.203 1.2.204 1.3.205 1.4.206 1.5.207 1.6.208 1.7.209 1.8.210 1.9.211 1.10.212 1.11.213 1.12.214 1.1.215 1.2.216 1.3.217 1.4.218 1.5.219 1.6.220 1.7.221 1.8.222 1.9.223 1.10.224 1.11.225 1.12.226 1.1.227 1.2.228 1.3.229 1.4.230 1.5.231 1.6.232 1.7.233 1.8.234 1.9.235 1.10.236 1.11.237 1.12.238 1.1.239 1.2.240 1.3.241 1.4.242 1.5.243 1.6.244 1.7.245 1.8.246 1.9.247 1.10.248 1.11.249 1.12.250 1.1.251 1.2.252 1.3.253 1.4.254 1.5.255 1.6.256 1.7.257 1.8.258 1.9.259 1.10.260 1.11.261 1.12.262 1.1.263 1.2.264 1.3.265 1.4.266 1.5.267 1.6.268 1.7.269 1.8.270 1.9.271 1.10.272 1.11.273 1.12.274 1.1.275 1.2.276 1.3.277 1.4.278 1.5.279 1.6.280 1.7.281 1.8.282 1.9.283 1.10.284 1.11.285 1.12.286 1.1.287 1.2.288 1.3.289 1.4.290 1.5.291 1.6.292 1.7.293 1.8.294 1.9.295 1.10.296 1.11.297 1.12.298 1.1.299 1.2.300 1.3.301 1.4.302 1.5.303 1.6.304 1.7.305 1.8.306 1.9.307 1.10.308 1.11.309 1.12.310 1.1.311 1.2.312 1.3.313 1.4.314 1.5.315 1.6.316 1.7.317 1.8.318 1.9.319 1.10.320 1.11.321 1.12.322 1.1.323 1.2.324 1.3.325 1.4.326 1.5.327 1.6.328 1.7.329 1.8.330 1.9.331 1.10.332 1.11.333 1.12.334 1.1.335 1.2.336 1.3.337 1.4.338 1.5.339 1.6.340 1.7.341 1.8.342 1.9.343 1.10.344 1.11.345 1.12.346 1.1.347 1.2.348 1.3.349 1.4.350 1.5.351 1.6.352 1.7.353 1.8.354 1.9.355 1.10.356 1.11.357 1.12.358 1.1.359 1.2.360 1.3.361 1.4.362 1.5.363 1.6.364 1.7.365 1.8.366 1.9.367 1.10.368 1.11.369 1.12.370 1.1.371 1.2.372 1.3.373 1.4.374 1.5.375 1.6.376 1.7.377 1.8.378 1.9.379 1.10.380 1.11.381 1.12.382 1.1.383 1.2.384 1.3.385 1.4.386 1.5.387 1.6.388 1.7.389 1.8.390 1.9.391 1.10.392 1.11.393 1.12.394 1.1.395 1.2.396 1.3.397 1.4.398 1.5.399 1.6.400 1.7.401 1.8.402 1.9.403 1.10.404 1.11.405 1.12.406 1.1.407 1.2.408 1.3.409 1.4.410 1.5.411 1.6.412 1.7.413 1.8.414 1.9.415 1.10.416 1.11.417 1.12.418 1.1.419 1.2.420 1.3.421 1.4.422 1.5.423 1.6.424 1.7.425 1.8.426 1.9.427 1.10.428 1.11.429 1.12.430 1.1.431 1.2.432 1.3.433 1.4.434 1.5.435 1.6.436 1.7.437 1.8.438 1.9.439 1.10.440 1.11.441 1.12.442 1.1.443 1.2.444 1.3.445 1.4.446 1.5.447 1.6.448 1.7.449 1.8.450 1.9.451 1.10.452 1.11.453 1.12.454 1.1.455 1.2.456 1.3.457 1.4.458 1.5.459 1.6.460 1.7.461 1.8.462 1.9.463 1.10.464 1.11.465 1.12.466 1.1.467 1.2.468 1.3.469 1.4.470 1.5.471 1.6.472 1.7.473 1.8.474 1.9.475 1.10.476 1.11.477 1.12.478 1.1.479 1.2.480 1.3.481 1.4.482 1.5.483 1.6.484 1.7.485 1.8.486 1.9.487 1.10.488 1.11.489 1.12.490 1.1.491 1.2.492 1.3.493 1.4.494 1.5.495 1.6.496 1.7.497 1.8.498 1.9.499 1.10.500 1.11.501 1.12.502 1.1.503 1.2.504 1.3.505 1.4.506 1.5.507 1.6.508 1.7.509 1.8.510 1.9.511 1.10.512 1.11.513 1.12.514 1.1.515 1.2.516 1.3.517 1.4.518 1.5.519 1.6.520 1.7.521 1.8.522 1.9.523 1.10.524 1.11.525 1.12.526 1.1.527 1.2.528 1.3.529 1.4.530 1.5.531 1.6.532 1.7.533 1.8.534 1.9.535 1.10.536 1.11.537 1.12.538 1.1.539 1.2.540 1.3.541 1.4.542 1.5.543 1.6.544 1.7.545 1.8.546 1.9.547 1.10.548 1.11.549 1.12.550 1.1.551 1.2.552 1.3.553 1.4.554 1.5.555 1.6.556 1.7.557 1.8.558 1.9.559 1.10.560 1.11.561 1.12.562 1.1.563 1.2.564 1.3.565 1.4.566 1.5.567 1.6.568 1.7.569 1.8.570 1.9.571 1.10.572 1.11.573 1.12.574 1.1.575 1.2.576 1.3.577 1.4.578 1.5.579 1.6.580 1.7.581 1.8.582 1.9.583 1.10.584 1.11.585 1.12.586 1.1.587 1.2.588 1.3.589 1.4.590 1.5.591 1.6.592 1.7.593 1.8.594 1.9.595 1.10.596 1.11.597 1.12.598 1.1.599 1.2.600 1.3.601 1.4.602 1.5.603 1.6.604 1.7.605 1.8.606 1.9.607 1.10.608 1.11.609 1.12.610 1.1.611 1.2.612 1.3.613 1.4.614 1.5.615 1.6.616 1.7.617 1.8.618 1.9.619 1.10.620 1.11.621 1.12.622 1.1.623 1.2.624 1.3.625 1.4.626 1.5.627 1.6.628 1.7.629 1.8.630 1.9.631 1.10.632 1.11.633 1.12.634 1.1.635 1.2.636 1.3.637 1.4.638 1.5.639 1.6.640 1.7.641 1.8.642 1.9.643 1.10.644 1.11.645 1.12.646 1.1.647 1.2.648 1.3.649 1.4.650 1.5.651 1.6.652 1.7.653 1.8.654 1.9.655 1.10.656 1.11.657 1.12.658 1.1.659 1.2.660 1.3.661 1.4.662 1.5.663 1.6.664 1.7.665 1.8.666 1.9.667 1.10.668 1.11.669 1.12.670 1.1.671 1.2.672 1.3.673 1.4.674 1.5.675 1.6.676 1.7.677 1.8.678 1.9.679 1.10.680 1.11.681 1.12.682 1.1.683 1.2.684 1.3.685 1.4.686 1.5.687 1.6.688 1.7.689 1.8.690 1.9.691 1.10.692 1.11.693 1.12.694 1.1.695 1.2.696 1.3.697 1.4.698 1.5.699 1.6.700 1.7.701 1.8.702 1.9.703 1.10.704 1.11.705 1.12.706 1.1.707 1.2.708 1.3.709 1.4.710 1.5.711 1.6.712 1.7.713 1.8.714 1.9.715 1.10.716 1.11.717 1.12.718 1.1.719 1.2.720 1.3.721 1.4.722 1.5.723 1.6.724 1.7.725 1.8.726 1.9.727 1.10.728 1.11.729 1.12.730 1.1.731 1.2.732 1.3.733 1.4.734 1.5.735 1.6.736 1.7.737 1.8.738 1.9.739 1.10.740 1.11.741 1.12.742 1.1.743 1.2.744 1.3.745 1.4.746 1.5.747 1.6.748 1.7.749 1.8.750 1.9.751 1.10.752 1.11.753 1.12.754 1.1.755 1.2.756 1.3.757 1.4.758 1.5.759 1.6.760 1.7.761 1.8.762 1.9.763 1.10.764 1.11.765 1.12.766 1.1.767 1.2.768 1.3.769 1.4.770 1.5.771 1.6.772 1.7.773 1.8.774 1.9.775 1.10.776 1.11.777 1.12.778 1.1.779 1.2.780 1.3.781 1.4.782 1.5.783 1.6.784 1.7.785 1.8.786 1.9.787 1.10.788 1.11.789 1.12.790 1.1.791 1.2.792 1.3.793 1.4.794 1.5.795 1.6.796 1.7.797 1.8.798 1.9.799 1.10.800 1.11.801 1.12.802 1.1.803 1.2.804 1.3.805 1.4.806 1.5.807 1.6.808 1.7.809 1.8.810 1.9.811 1.10.812 1.11.813 1.12.814 1.1.815 1.2.816 1.3.817 1.4.818 1.5.819 1.6.820 1.7.821 1.8.822 1.9.823 1.10.824 1.11.825 1.12.826 1.1.827 1.2.828 1.3.829 1.4.830 1.5.831 1.6.832 1.7.833 1.8.834 1.9.835 1.10.836 1.11.837 1.12.838 1.1.839 1.2.840 1.3.841 1.4.842 1.5.843 1.6.844 1.7.845 1.8.846 1.9.847 1.10.848 1.11.849 1.12.850 1.1.851 1.2.852 1.3.853 1.4.854 1.5.855 1.6.856 1.7.857 1.8.858 1.9.859 1.10.860 1.11.861 1.12.862 1.1.863 1.2.864 1.3.865 1.4.866 1.5.867 1.6.868 1.7.869 1.8.870 1.9.871 1.10.872 1.11.873 1.12.874 1.1.875 1.2.876 1.3.877 1.4.878 1.5.879 1.6.880 1.7.881 1.8.882 1.9.883 1.10.884 1.11.885 1.12.886 1.1.887 1.2.888 1.3.889 1.4.890 1.5.891 1.6.892 1.7.893 1.8.894 1.9.895 1.10.896 1.11.897 1.12.898 1.1.899 1.2.900 1.3.901 1.4.902 1.5.903 1.6.904 1.7.905 1.8.906 1.9.907 1.10.908 1.11.909 1.12.910 1.1.911 1.2.912 1.3.913 1.4.914 1.5.915 1.6.916 1.7.917 1.8.918 1.9.919 1.10.920 1.11.921 1.12.922 1.1.923 1.2.924 1.3.925 1.4.926 1.5.927 1.6.928 1.7.929 1.8.930 1.9.931 1.10.932 1.11.933 1.12.934 1.1.935 1.2.936 1.3.937 1.4.938 1.5.939 1.6.940 1.7.941 1.8.942 1.9.943 1.10.944 1.11.945 1.12.946 1.1.947 1.2.948 1.3.949 1.4.950 1.5.951 1.6.952 1.7.953 1.8.954 1.9.955 1.10.956 1.11.957 1.12.958 1.1.959 1.2.960 1.3.961 1.4.962 1.5.963 1.6.964 1.7.965 1.8.966 1.9.967 1.10.968 1.11.969 1.12.970 1.1.971 1.2.972 1.3.973 1.4.974 1.5.975 1.6.976 1.7.977 1.8.978 1.9.979 1.10.980 1.11.981 1.12.982 1.1.983 1.2.984 1.3.985 1.4.986 1.5.987 1.6.988 1.7.989 1.8.990 1.9.991 1.10.992 1.11.993 1.12.994 1.1.995 1.2.996 1.3.997 1.4.998 1.5.999 1.6.1000 1.7.1001 1.8.1002 1.9.1003 1.10.1004 1.11.1005 1.12.1006 1.1.1007 1.2.1008 1.3.1009 1.4.1010 1.5.1011 1.6.1012 1.7.1013 1.8.1014 1.9.1015 1.10.1016 1.11.1017 1.12.1018 1.1.1019 1.2.1020 1.3.1021 1.4.1022 1.5.1023 1.6.1024 1.7.1025 1.8.1026 1.9.1027 1.10.1028 1.11.1029 1.12.1030 1.1.1031 1.2.1032 1.3.1033 1.4.1034 1.5.1035 1.6.1036 1.7.1037 1.8.1038 1.9.1039 1.10.1040 1.11.1041 1.12.1042 1.1.1043 1.2.1044 1.3.1045 1.4.1046 1.5.1047 1.6.1048 1.7.1049 1.8.1050 1.9.1051 1.10.1052 1.11.1053 1.12.1054 1.1.1055 1.2.1056 1.3.1057 1.4.1058 1.5.1059 1.6.1060 1.7.1061 1.8.1062 1.9.1063 1.10.1064 1.11.1065 1.12.1066 1.1.1067 1.2.1068 1.3.1069 1.4.1070 1.5.1071 1.6.1072 1.7.1073 1.8.1074 1.9.1075 1.10.1076 1.11.1077 1.12.1078 1.1.1079 1.2.1080 1.3.1081 1.4.1082 1.5.1083 1.6.1084 1.7.1085 1.8.1086 1.9.1087 1.10.1088 1.11.1089 1.12.1090 1.1.1091 1.2.1092 1.3.1093 1.4.1094 1.5.1095 1.6.1096 1.7.1097 1.8.1098 1.9.1099 1.10.1100 1.11.1101 1.12.1102 1.1.1103 1.2.1104 1.3.1105 1.4.1106 1.5.1107 1.6.1108 1.7.1109 1.8.1110 1.9.1111 1.10.1112 1.11.1113 1.12.1114 1.1.1115 1.2.1116 1.3.1117 1.4.1118 1.5.1119 1.6.1120 1.7.1121 1.8.1122 1.9.1123 1.10.1124 1.11.1125 1.12.1126 1.1.1127 1.2.1128 1.3.1129 1.4.1130 1.5.1131 1.6.1132 1.7.1133 1.8.1134 1.9.1135 1.10.1136 1.11.1137 1.12.1138 1.1.1139 1.2.1140 1.3.1141 1.4.1142 1.5.1143 1.6.1144 1.7.1145 1.8.1146 1.9.1147 1.10.1148 1.11.1149 1.12.1150 1.1.1151 1.2.1152 1.3.1153 1.4.1154 1.5.1155 1.6.1156 1.7.1157 1.8.1158 1.9.1159 1.10.1160 1.11.1161 1.12.1162 1.1.1163 1.2.1164 1.3.1165 1.4.1166 1.5.1167 1.6.1168 1.7.1169 1.8.1170 1.9.1171 1.10.1172 1.11.1173 1.12.1174 1.1.1175 1.2.1176 1.3.1177 1.4.1178 1.5.1179 1.6.1180 1.7.1181 1.8.1182 1.9.1183 1.10.1184 1.11.1185 1.12.1186 1.1.1187 1.2.1188 1.3.1189 1.4.1190 1.5.1191 1.6.1192 1.7.1193 1.8.1194 1.9.1195 1.10.1196 1.11.1197 1.12.1198 1.1.1199 1.2.1200 1.3.1201 1.4.1202 1.5.1203 1.6.1204 1.7.1205 1.8.1206 1.9.1207 1.10.1208 1.11.1209 1.12.1210 1.1.1211 1.2.1212 1.3.1213 1.4.1214 1.5.1215 1.6.1216 1.7.1217 1.8.1218 1.9.1219 1.10.1220 1.11.1221 1.12.1222 1.1.1223 1.2.1224 1.3.1225 1.4.1226 1.5.1227 1.6.1228 1.7.1229 1.8.1230 1.9.1231 1.10.1232 1.11.1233 1.12.1234 1.1.1235 1.2.1236 1.3.1237 1.4.1238 1.5.1239 1.6.1240 1.7.1241 1.8.1242 1.9.1243 1.10.1244 1.11.1245 1.12.1246 1.1.1247 1.2.1248 1.3.1249 1.4.1250 1.5.1251 1.6.1252 1.7.1253 1.8.1254 1.9.1255 1.10.1256 1.11.1257 1.12.1258 1.1.1259 1.2.1260 1.3.1261 1.4.1262 1.5.1263 1.6.1264 1.7.1265 1.8.1266 1.9.1267 1.10.1268 1.11.1269 1.12.1270 1.1.1271 1.2.1272 1.3.1273 1.4.1274 1.5.1275 1.6.1276 1.7.1277 1.8.1278 1.9.1279 1.10.1280 1.11.1281 1.12.1282 1.1.1283 1.2.1284 1.3.1285 1.4.1286 1.5.1287 1.6.1288 1.7.1289 1.8.1290 1.9.1291 1.10.1292 1.11.1293 1.12.1294 1.1.1295 1.2.1296 1.3.1297 1.4.1298 1.5.1299 1.6.1300 1.7.1301 1.8.1302 1.9.1303 1.10.1304 1.11.1305 1.12.1306 1.1.1307 1.2.1308 1.3.1309 1.4.1310 1.5.1311 1.6.1312 1.7.1313 1.8.1314 1.9.1315 1.10.1316 1.11.1317 1.12.1318 1.1.1319 1.2.1320 1.3.1321 1.4.1322 1.5.1323 1.6.1324 1.7.1325 1.8.1326 1.9.1327 1.10.1328 1.11.1329 1.12.1330 1.1.1331 1.2.1332 1.3.1333 1.4.1334 1.5.1335 1.6.1336 1.7.1337 1.8.1338 1.9.1339 1.10.1340 1.11.1341 1.12.1342 1.1.1343 1.2.1344 1.3.1345 1.4.1346 1.5.1347 1.6.1348 1.7.1349 1.8.1350 1.9.1351 1.10.1352 1.11.1353 1.12.1354 1.1.1355 1.2.1356 1.3.1357 1.4.1358 1.5.1359 1.6.1360 1.7.1361 1.8.1362 1.9.1363 1.10.1364 1.11.1365 1.12.1366 1.1.1367 1.2.1368 1.3.1369 1.4.1370 1.5.1371 1.6.1372 1.7.1373 1.8.1374 1.9.1375 1.10.1376 1.11.1377 1.12.1378 1.1.1379 1.2.1380 1.3.1381 1.4.1382 1.5.1383 1.6.1384 1.7.1385 1.8.1386 1.9.1387 1.10.1388 1.11.1389 1.12.1390 1.1.1391 1.2.1392 1.3.1393 1.4.1394 1.5.1395 1.6.1396 1.7.1397 1.8.1398 1.9.1399 1.10.1400 1.11.1401 1.12.1402 1.1.1403 1.2.1404 1.3.1405 1.4.1406 1.5.1407 1.6.1408 1.7.1409 1.8.1410 1.9.1411 1.10.1412 1.11.1413 1.12.1414 1.1.1415 1.2.1416 1.3.1417 1.4.1418 1.5.1419 1.6.1420 1.7.1421 1.8.1422 1.9.1423 1.10.1424 1.11.1425 1.12.1426 1.1.1427 1.2.1428 1.3.1429 1.4.1430 1.5.1431 1.6.1432 1.7.1433 1.8.1434 1.9.1435 1.10.1436 1.11.1437 1.12.1438 1.1.1439 1.2.1440 1.3.1441 1.4.1442 1.5.1443 1.6.1444 1.7.1445 1.8.1446 1.9.1447 1.10.1448 1.11.1449 1.12.1450 1.1.1451 1.2.1452 1.3.1453 1.4.1454 1.5.1455 1.6.1456 1.7.1457 1.8.1458 1.9.1459 1.10.1460 1.11.1461 1.12.1462 1.1.1463 1.2.1464 1.3.1465 1.4.1466 1.5.1467 1.6.1468 1.7.1469 1.8.1470 1.9.1471 1.10.1472 1

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State of Maryland / Department of Health and Mental Hygiene

97 09083

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>NORMAN EARL DORNEY</b>				2. Date of Death Month <b>March</b> Day <b>11</b> Year <b>1997</b>				3. Time of Death <b>0235</b>					
4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Harford</b>				4c. County of Death <b>Harford</b>					
5. Social Security Number <b>215-30-7873</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>12-10-32</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Street</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street end Number <b>1108 Priestford Road</b>				10f. Zip Code <b>21154</b>				10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>				16b. Kind of Business/Industry <b>Manufacturing</b>					
17. Father's Name (First, Middle, Last) <b>Lester Smith Dorney</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Emma O. Knight</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Hazel I. Dorney</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1108 Priesford Road Street, MD 21154</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Darlington Cemetery</b>		Date <b>3/14</b>		20c. Location - City or Town, State <b>Darlington, MD</b>					
21. Signature of Funeral Service Licensee <b>Jeffrey P. Lardidge</b>						22. Name and Address of Facility <b>Harkins Funeral Home, Inc., Delta, PA</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple sclerosis</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>75 years</b>  e. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pyelonephritis</b> <b>Cerebrovascular accident</b>													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <b>John F. Lardidge</b>						29c. License number <b>028339</b>		29d. Date signed (Month, Day, Year) <b>March 11, 1997</b>					
30. Name and address of person who completed cause of death (item 23e) (Type, Print) <b>LINDA FISCH 101 E Wheel Road Bel Air MD 21015</b>													
31. Date filed (Month, Day, Year) <b>MAR 12 1997</b>						32. Registrar's Signature <b>John F. Lardidge</b>							

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09084

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE KATHERINE DELANEY

2. Date of Death

Month Day Year  
Feb. 28 1997

3. Time of Death

1:55 PM

4a. Facility Name (If not institution, give street and number)

Bel Air Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

195-28-3150

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 2, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

410 East McPhail Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Wally (nmn) Jones

18. Mother's Name (First, Middle, Maiden Surname)

Dora (nmn) Hash

19a. Informant's Name/Relationship (Type, Print)

Barbara J. Ranalli, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1409 A Calvary Rd., Abingdon, Md. 21009

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris & Co., Inc. 3/1/97 West Chester, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Howard K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate interval between Onset and Death

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident - Brainstem

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DR MD

29c. License number

D34652

29d. Date signed (Month, Day, Year)

February 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Haswell 2 North Ave. Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09085

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JOYCE

EVERSOLE

2. Date of Death

Month Day Year  
March 6, 1997

3. Time of Death

2:04 A.M.

4a. Facility Name (If not institution, give street and number)

Memorial Hospital &amp; Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

236-54-8834

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept 25, 1936 West Virginia

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Garrett

10c. City, Town or Location

Swanton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Box 150 Lower Green Glade Rd.

10f. Zip Code

21561

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Employee Automated Packaging Packaging Industry

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Arthur Hartman

18. Mother's Name (First, Middle, Maiden Surname)

Zena Simmons

19a. Informant's Name/Relationship (Type, Print)

David Eversole

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt 1 Box 178-A4, Keyser Wv. 26726

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pctomac Memorial Gardens Mar 9, 1997 Keyser, WV

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Wayne Bond

22. Name and Address of Facility

Boal Funeral Home

111 Church St, Westernport, md. 21562

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Advanced Carcinoma of Colon

Approximate  
Interval Between  
Onset and Death

4 Years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Zaman MD

29c. License number

D 23371

29d. Date signed (Month, Day, Year)

MARCH 6 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zaman, Johnson Heights Medical Building, Suite 102 Cumberland, MD. 21502

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09086

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Francis X. Farrington

2. Date of Death

March 5, 1997

3. Time of Death

3:34 PM

4a. Facility Name (If not institution, give street and number)

10410 Proctor Street

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

072-09-7989

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 14, 1903

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10410 Proctor Street

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Proofreader

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Farrington

18. Mother's Name (First, Middle, Maiden Surname)

Mary Burke

19a. Informant's Name/Relationship (Type, Print)

Mary Ann Farrington

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10410 Proctor Street Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery 3/08/97 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W. Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Cerebro Vascular Accident

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Subdural Hematoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 35162

29d. Date signed (Month, Day, Year)

March 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael S. Schindler, M.D. 10801 Lockwood Drive #200 Silver Spring, Maryland 20901

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



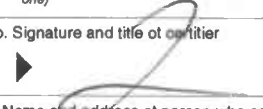
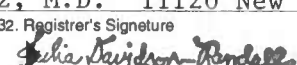
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09087

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HOPE MARY FARMER</b>				2. Date of Death Month <b>MARCH</b> Day <b>7</b> Year <b>1997</b>		3. Time of Death <b>6:30 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>2210 Hallow Lane</b>				4b. City, Town, or Location of Death <b>Bowie</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>578-60-6500</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 22, 1942</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Bowie</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2210 Hallow Lane</b>		10f. Zip Code <b>20716</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse's Aide</b>		16b. Kind of Business/Industry <b>Health Care</b>				
17. Father's Name (First, Middle, Last) <b>Anthony Quinto</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Rosile Vassallo</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mary Hope Pinkney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10853 Amherst Avenue #002 Silver Spring, Maryland 20902</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>3/8/97 Alexandria, Virginia</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Cancer to Liver, Primary Site Unknown</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. Metastatic Cancer to Liver, Primary Site Unknown</b> Due to (or as a consequence of):  <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>				Approximate Interval Between Onset and Death <b>Weeks</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No		
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>00000000</b>		
29d. Date signed (Month, Day, Year) <b>March 7, 1997</b>				29e. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael L. Leibowitz, M.D. 11120 New Hampshire Avenue #305 Silver Spring, MD 20904</b>				
31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09088

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine E. Fife</b>				2. Date of Death Month <b>March</b> Day <b>7</b> Year <b>1997</b>		3. Time of Death <b>11:30 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>95 Dawson Avenue #602</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>214-28-4231</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 20, 1930</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>95 Dawson Avenue, #602</b>		10f. Zip Code <b>20850</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Assistant</b>		16b. Kind of Business/Industry <b>Health Care</b>			
	17. Father's Name (First, Middle, Last) <b>Thomas Ricketts</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Shaw</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary S. Norris / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28636 Kempton Road, Damascus, MD 20872</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		20d. Date <b>March 10, 1997</b>	
	21. Signature of Funeral Service Licensee <b>Michelle P. Kutta</b> M00348		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Uncontrolled Hypertension</b> Due to (or as a consequence of):  b. <b>Uncontrolled Diabetes</b> Due to (or as a consequence of):  c. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was cause referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>S. Abate</b>				29c. License number <b>D50296</b>		29d. Date signed (Month, Day, Year) <b>March 7, 1997</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Shastine Abate, M.D., 6111 Executive Blvd., Rockville, Maryland 20852</b>							
	31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>				32. Registrar's Signature <b>Johanna Davidson-Rendell</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09089

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Edward Fellin

2. Date of Death

March 4, 1997

3. Time of Death

9:30A.

4a. Facility Name (If not institution, give street and number)

9720 - 51st Avenue

4b. City, Town, or Location of Death

College Park

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

165-16-0126

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 12, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9720 - 51st Avenue

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: 1942-194513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contracting Agent

16b. Kind of Business/Industry

United States  
Naval Department

17. Father's Name (First, Middle, Last)

Victor

Fellin

18. Mother's Name (First, Middle, Maiden Summa)

Cecilia

Martini

19a. Informant's Name/Relationship (Type, Print)

Maisie Lee Fellin (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3/7/1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Road Beltsville, Maryland 2070523a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Prob. Ventricular fibrillation

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Coronary atherosclerosis

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Ulcerative Colitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

Faranak F. Sotoudeh

29c. License number

M 23890

29d. Date signed (Month, Day, Year)

March 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Faranak F. Sotoudeh, M.D. 7525 Greenway Center Drive, #209 Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09090

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Warren E. Field

2. Date of Death

March 9, 1997

3. Time of Death

12:00 Noon

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

15713 Mahogany Circle, #105

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

217-72-1050

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 8, 1957

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15713 Mahogany Circle, #105

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Manager

16b. Kind of Business/Industry

Water Systems

17. Father's Name (First, Middle, Last)

Chester J. Field

18. Mother's Name (First, Middle, Maiden Surname)

Anne J. Caillabet

19a. Informant's Name/Relationship (Type, Print)

Anne J. Caillabet / mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

3-10-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Presumed Jacob Creutzfeldt Disease

XXXXXX (not biopsy proven)

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George Kattah

29c. License number

D.C. 6848

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jorge C. Kattah, M. D., 3800 Reservoir Road, NW, Washington, DC 20007

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09091

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Woodrow Wilson Ford

2. Date of Death

03<sup>Month</sup> 09<sup>Day</sup> 1997<sup>Year</sup>

3. Time of Death

3:20 P.M.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

216-07-6250

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 4, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Churchville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

611 Calvary Road

10f. Zip Code

21028

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1940-61

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Civil Service

16b. Kind of Business/Industry

U.S. Govt.

17. Father's Name (First, Middle, Last)

Bartlett Ford

18. Mother's Name (First, Middle, Maiden Surname)

Ida Shane

19a. Informant's Name/Relationship (Type, Print)

Mrs. June F. Mullhausen(daughter) 611 Calvary Road, Churchville, MD 21028

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R. A. Ferris & Co, Inc.

Date

3/11/97

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Kristen Amy Unglesbee

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction  
Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

c. CVA.

Due to (or as a consequence of):

d. tumor in Sella Turcica

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Brian T. Yeo-M.D., FACC

29c. License number

D15152

29d. Date signed (Month, Day, Year)

3/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801 S. Union Ave Havre De Grace, MD 21078

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Johanna R. Ruckel

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used in the study.

3. The third part is a discussion of the results of the study.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of appendices.

6. The sixth part is a list of figures and tables.

7. The seventh part is a list of footnotes.

8. The eighth part is a list of symbols and abbreviations.

9. The ninth part is a list of acknowledgments.

10. The tenth part is a list of references.

11. The eleventh part is a list of appendices.

12. The twelfth part is a list of figures and tables.

13. The thirteenth part is a list of footnotes.

14. The fourteenth part is a list of symbols and abbreviations.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09092

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Robert Luck FERRELL</b>					2. Date of Death Month <b>March</b> Day <b>9</b> Year <b>1997</b>		3. Time of Death <b>5:30 am</b>						
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>					4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>						
<b>Funeral Director</b>	5. Social Security Number <b>220-76-3395</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 31, 1931</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>					
	Usual Residence of Decedent													
10a. State <b>Maryland</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>6116 Belair Road</b>					10f. Zip Code <b>21206</b>			10g. Citizen of What Country? <b>USA</b>						
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+) <b>n/a</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>n/a</b>			16b. Kind of Business/Industry <b>n/a</b>						
17. Father's Name (First, Middle, Last) <b>Robert Price Ferrell</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Sheldon Maxwell</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Katherine F. Jones, sister</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1222 Conowingo Road, Bel Air, Maryland 21014</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Churchville Presbyterian Cem.</b>			Date <b>3/12/97</b>		20c. Location - City or Town, State <b>Churchville, Md.</b>					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21002</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
<table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;">                 Immediate Cause (Final disease or condition resulting in death)                   e. <b>Aspiration Pneumonia</b>                  Due to (or as a consequence of):                   b. <b>Mental Retardation</b>                  Due to (or as a consequence of):                   c.                   Due to (or as a consequence of):                   d.                   Due to (or as a consequence of):             </td> <td style="width:70%; vertical-align: top;"> <table border="0" style="width:100%;"> <tr> <td style="width:60%;"></td> <td style="width:40%; text-align: center;">                 Approximate Interval Between Onset and Death   <b>1 Month</b>   <b>65 Years</b> </td> </tr> </table> </td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)  e. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):  b. <b>Mental Retardation</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):	<table border="0" style="width:100%;"> <tr> <td style="width:60%;"></td> <td style="width:40%; text-align: center;">                 Approximate Interval Between Onset and Death   <b>1 Month</b>   <b>65 Years</b> </td> </tr> </table>		Approximate Interval Between Onset and Death  <b>1 Month</b>  <b>65 Years</b>
Immediate Cause (Final disease or condition resulting in death)  e. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):  b. <b>Mental Retardation</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):	<table border="0" style="width:100%;"> <tr> <td style="width:60%;"></td> <td style="width:40%; text-align: center;">                 Approximate Interval Between Onset and Death   <b>1 Month</b>   <b>65 Years</b> </td> </tr> </table>		Approximate Interval Between Onset and Death  <b>1 Month</b>  <b>65 Years</b>											
	Approximate Interval Between Onset and Death  <b>1 Month</b>  <b>65 Years</b>													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier 					29c. License number <b>RD2119</b>			29d. Date signed (Month, Day, Year) <b>March 10, 1997</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ronald Jeffreys M.D. 9000 Franklin Square Drive, Baltimore, MD 21237</b>														
31. Date filed (Month, Day, Year) <b>MAR 12 1997</b>														
32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09093

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICK J.

FLAHERTY

2. Date of Death  
Month Day Year  
March 6, 19973. Time of Death  
2:30 P.M.

4a. Facility Name (If not institution, give street and number)

8 Peach Orchard Ct.

4b. City, Town, or Location of Death

Brunswick

4c. County of Death

Frederick

5. Social Security Number

220-62-8788

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 18, 1953

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8 Peach Orchard Ct.

10f. Zip Code

21716

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouse Manager

16b. Kind of Business/Industry

Soda Company

17. Father's Name (First, Middle, Last)

Bernard

Flaherty

18. Mother's Name (First, Middle, Maiden Surname)

Patricia A. Hayden

19a. Informant's Name/Relationship (Type, Print)

Patti Lynn Flaherty/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Peach Orchard Ct. / Brunswick, Md. 21716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Park Heights Cemetery

Data

3-8-97

20c. Location - City or Town, State

Brunswick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike / Frederick, Md. 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41619

29d. Date signed (Month, Day, Year)

March 7, 1993

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Lerner / 15 E. Frederick, St. / Walkersville, Md. 21793

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the significance of the study.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

7. The seventh part of the report is an appendix. It includes a list of all the figures and tables used in the study, along with a description of each one.

8. The eighth part of the report is a list of acknowledgments. It includes a list of all the people and organizations that helped with the study, along with a description of their contributions.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 8 Per FH Film G746 4-9-97 rja

## Certificate of Death

97 09094

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PEARL VIOLA GROWDEN</b>		2. Date of Death Month Day Year <b>March 9, 1997</b>		3. Time of Death <b>12:22 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>
Funeral Director	5. Social Security Number <b>218-24-8219</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>MAY 13 1919</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>PA.</b>		10b. County <b>BEDFORD</b>
	10c. City, Town or Location <b>BEDFORD</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>RFD#3 BOX#609</b>		10f. Zip Code <b>15522</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>HOUSE KEEPER</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSE KEEPER</b>
	17. Father's Name (First, Middle, Last) <b>ANDREW BOSLEY</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MAY MILLER</b>		
	19e. Informant's Name/Relationship (Type, Print) <b>EDITH SHEPHERD</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RFD#3 BEDFORD, PA. 15522</b>		
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CENTERVILLE FELLOWSHIP MARCH 12 1997 CENTERVILLE PA.</b>		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>		22. Name and Address of Facility <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 21502</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Metastatic renal cell CA</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>3 weeks</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year) <b>M</b>		28d. Describe how Injury occurred	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>N. McCullough MD</i>		29c. License number <b>D44712</b>	
29d. Date signed (Month, Day, Year) <b>March 10, 1997</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. N. McCullough, 715 Williams St., Cumberland, MD 21502</b>			
31. Date filed <b>MAR 10 1997</b>		32. Registrar's Signature <i>John H. ...</i>			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09095

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Elmer Gable</u>				2. Date of Death Month <u>March</u> Day <u>15</u> Year <u>97</u>		3. Time of Death <u>3:45 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death	
Funeral Director	5. Social Security Number <u>217-20-3142</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>71</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>May 5, 1925</u>	9. Birthplace (State or Foreign Country) <u>MD</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>baltimore</u>		10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>788 George Ave</u>				10f. Zip Code <u>21221</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u></u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housewife</u>		16b. Kind of Business/Industry <u>N/A</u>		
17. Father's Name (First, Middle, Last) <u>Roy Wilburn</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Grace Hoover</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Leon J. Gable/Husband</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>788 George Ave Baltimore, MD 21221</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>New Oxford Cemetery</u>		Date <u>Mar 19, 1997</u>		20c. Location - City or Town, State <u>New Oxford, PA</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Feiser Funeral Home, Inc</u> <u>302 Lincolnway West New Oxford, PA 17350</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. <u>multi system organ failure</u> Due to (or as a consequence of):								<u>24 hrs</u>
b. <u>abdominal compartment syndrome</u> Due to (or as a consequence of):								<u>2 days</u>
c. <u>exploratory laparotomy with coagulopathy</u> Due to (or as a consequence of):								<u>4 days</u>
d. <u>sepsis</u> Due to (or as a consequence of):								<u>&gt; 7 days</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>infected aortic valve bypass graft, (C)</u> <u>retroperitoneal abscess, chronic renal failure,</u> <u>GI bleed, hypertension</u>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <u>[Signature]</u> , MD				29c. License number <u>N8292</u>		29d. Date signed (Month, Day, Year) <u>March 15, 1997</u>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>J Schwalb, MD Johns Hopkins Bayview Medical Center</u>								
31. Date filed (Month, Day, Year) <u>MAR 25 1997</u>				32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician or Attending Physician: The law requires that the death certificate be executed and signed by a physician or attending physician after death.

Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09096

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ephraim E. Gavers

2. Date of Death

Month 6, Day 1997 Year

3. Time of Death

1:40 P.M.

4a. Facility Name (If not institution, give street and number)

Mariner Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-07-8700

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 3, Day 27, Year 1901

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7525 Carroll Street

10f. Zip Code

20912

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Literature Evangelist

18b. Kind of Business/Industry

Religious

17. Father's Name (First, Middle, Last)

Frederick Gavers

18. Mother's Name (First, Middle, Maiden Surname)

Mary Richards

19a. Informant's Name/Relationship (Type, Print)

Roy A. Gordon (Executor)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

407 Fernside Pl., Far Rockaway, New York 11691

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Cemetery

3/11/97

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility McGuire Funeral Service, Inc.  
7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE  
Due to (or as a consequence of):b. CEREBROVASCULAR ACCIDENT  
Due to (or as a consequence of):c. CARCINOMA OF PROSTATE  
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (disease or injury that initiated events resulting in death) last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL CYST.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D3692

29d. Date signed (Month, Day, Year)

MARCH 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANEES AHSAN, 7618 CARROLL AVE. SUITE 380, TAKOMA PARK, MD

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Davidson-Randall

20912

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

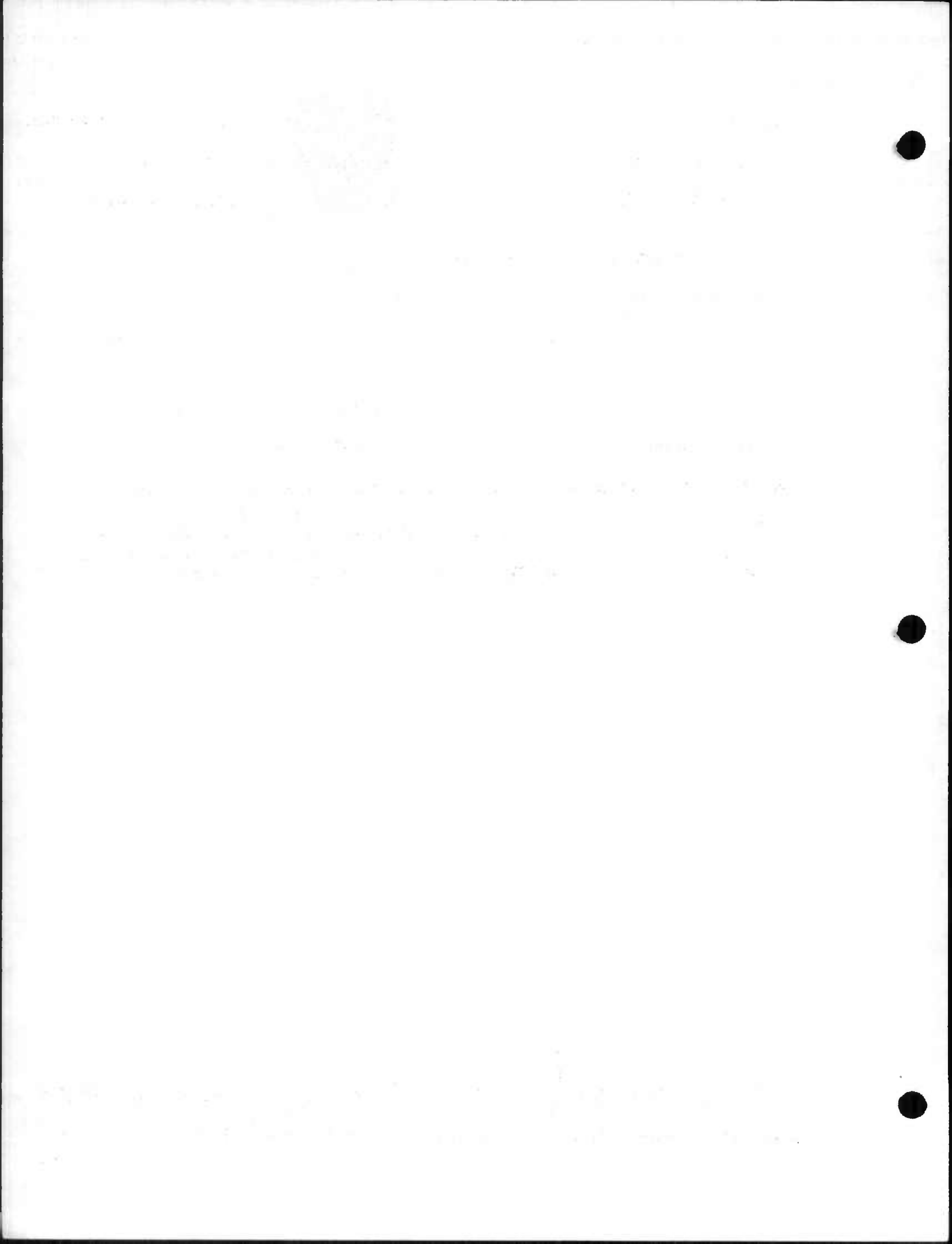
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #12, 19b, JW, Montg. Cty.

## Certificate of Death

Reg. No.

97 09097

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph A. Gallagher

2. Date of Death

March 5, 1997

3. Time of Death

6:15 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

403 Russell Avenue, #604

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

521-12-6924

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 6, 1915

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

403 Russell Avenue, #604

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates: 1948-197913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Ambrose Stephen Gallagher

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Roach

19a. Informant's Name/Relationship (Type, Print)

Jean P. Gallagher/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

403 Russell Avenue, #604, Gaithersburg, MD 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

March 9, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michelle J. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Spinal Cord Injury

Due to (or as a consequence of):

b. Osteoporosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen J. Newman

29c. License number

D1504C

29d. Date signed (Month, Day, Year)

March 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen J. Newman, M.D., 11500 Old Georgetown Road, Rockville, Maryland 20852-2735

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09098

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn M. German

2. Date of Death

Month Day Year  
March 9, 1997

3. Time of Death

11:45 pm

4a. Facility Name (If not institution, give street and number)

Mediplex of Montgomery Village

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

217-01-7258

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
March 26, 1911

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

411 Chestnut Ave.

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Vincent Mullican

18. Mother's Name (First, Middle, Maiden Surname)

Annie McCarthy

19a. Informant's Name/Relationship (Type, Print)

Thomas German, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19902 Waxmyrtle Way, Gaithersburg, MD 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Cemetery

Date

Mar 12, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Drive, Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE VALVULAR CARDIAC DISEASE

Due to (or as a consequence of):

b. Hepatopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

B30692

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gabriel A. Berrebi, M.D., 15200 Shady Grove Road, #305 Rockville, MD 20850

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09099

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ISRAEL

GALARZA

2. Date of Death

Month Day Year  
MARCH 8 1997

3. Time of Death

1724 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578-60-1070

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 13, 1926

9. Birthplace (State or Foreign Country)

PERU

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8151 NEEDWOOD ROAD

10f. Zip Code

20855

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:  
PERUVIAN

14. Race - American Indian, Black, White, etc.

Specify:  
WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

GRACE GALARZA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8151 NEEDWOOD ROAD ROCKVILLE, MARYLAND 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

3/14/97

20c. Location - City or Town, State

SILVER SPRING, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FRANCIS J. COLLINS FUNERAL HOME, INC.

500 UNIVERSITY BLVD., W., SILVER SPRING, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

240898

29d. Date signed (Month, Day, Year)

March 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miriam Martin

9901 Medical Center Dr. Rockville MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

97 09100

Amended # 10f, 3/24/97, JW, Montg. Cty.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hermine

Gholson

2. Date of Death

Month Day Year  
March 6, 1997

3. Time of Death

10:28 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5101 Ridgefield Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577.86.4816

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 15, 1909

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5101 RIDGEFIELD ROAD

10f. Zip Code

~~20806~~ 20816

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

UNKNOWN

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

LISA McALLISTER GRAND DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4336 HORTENSIA ST. SAN DIEGO, CALIFORNIA 92111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

3/24/97

20c. Location - City or Town, State

SILVER SPRING MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility JOSEPH GAWLER'S SONS, INC.  
5130 WISCONSIN AVE. N.W., WASHINGTON, DC 2001623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 MONTH

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST MASTECTOMY BILATERAL FOR BREAST CANCER,

PERIPHERAL NEURO PATHY ANGINA PECTORIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?

NO

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Susan Miller, M.D. 5530 Wisconsin Ave. #915 Chevy Chase, Md. 20815

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09101

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Claude Monique Guercin

2. Date of Death

Month Day Year

March 8, 1997

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

15301 PINE ORCHARD DRIVE 1D

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

071-30-5850

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 16, 1919

9. Birthplace (State or Foreign Country)

France

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15301 Pine Orchard Drive 1D

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Charles Spira

18. Mother's Name (First, Middle, Maiden Surname)

Andera Perquel

19a. Informant's Name/Relationship (Type, Print)

Michael P. Guercin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7406 Cedar Avenue Takoma Park, Maryland 20912

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

3/11/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Cardiac Arrest

Due to (or as a consequence of):

b.

Ischemic Cardiomyopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

immediate

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending investigation  
☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Gallino

29c. License number

D33067

29d. Date signed (Month, Day, Year)

3-10-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Gallino, MD 106 Irving St NW Wash DC 20010

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09102

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIE G. HOPKINS</b>				2. Date of Death Month Day Year <b>MARCH 8 1997</b>		3. Time of Death <b>2:20PM</b>																														
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>																														
Funeral Director	5. Social Security Number <b>164-26-6739</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 31, 1900</b>																														
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>CUMBERLAND</b>																														
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>941 BISHOP WALSH ROAD, APT.#14</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>																														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>																														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>HOME</b>																																
	17. Father's Name (First, Middle, Last) <b>G. WILLIAM McDERMOTT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MATILDA HEINZ</b>																																
	19a. Informant's Name/Relationship (Type, Print) <b>REV. ROBERT F. HOPKINS/SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>941 BISHOP WALSH ROAD, APT.#14, CUMBERLAND, MD 21502</b>																																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. MARY'S CEMETERY</b>		20c. Location - City or Town, State <b>CUMBERLAND, MD</b>		20d. Date <b>3/11/97</b>																														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502</b>																																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																				
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td colspan="6">           a. <b>CONGESTIVE HEART FAILURE</b>            Due to (or as a consequence of):         </td> <td>48 hours</td> </tr> <tr> <td colspan="6">           b. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>            Due to (or as a consequence of):         </td> <td>20 years</td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">d. Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):						48 hours	b. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):						20 years	c. Due to (or as a consequence of):							d. Due to (or as a consequence of):						
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):						48 hours																													
b. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):						20 years																															
c. Due to (or as a consequence of):																																					
d. Due to (or as a consequence of):																																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PARALYTIC ILEUS</b> <b>SMALL BOWEL OBSTRUCTION SUSPECTED, NOT PROVEN</b>																																					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined																																					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																					
28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																					
29b. Signature and title of certifier  29c. License number <b>D13601</b> 29d. Date signed (Month, Day, Year) <b>MARCH 10 1997</b>																																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>V.R. FELIPA M.D.FACP 925 BISHOP WALSH ROAD CUMBERLAND MD 21502</b>																																					
31. Date filed (Month, Day, Year) <b>MAR 10 1997</b> 32. Registrar's Signature 																																					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

2 x 10

100

100

100

100

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09103

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Madeline Henry

2. Date of Death

Month  
MARCHDay  
6Year  
1997

3. Time of Death

8:35 AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

215-12-2039

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year

Mar 2, 1913

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

LaVale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

510 Maryland Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Manager

16b. Kind of Business/Industry

Shriver Oil Co.

17. Father's Name (First, Middle, Last)

George Wintermyer

18. Mother's Name (First, Middle, Maiden Surname)

Catherine (nm)

19a. Informant's Name/Relationship (Type, Print)

Floyd Kaylor-cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

510 Maryland Street LaVale MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SS Peter Paul Cemetery

Date

03/08

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home

Cumberland, MD 21502

23a. Pertinent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

17 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PULMONARY EMBOLISM

Due to (or as a consequence of):

17 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE

ARTERIOSCLEROSIS

CERVICAL VERTEBRAL FRACTURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

George M. Breza MD

29c. License number

D12532

29d. Date signed (Month, Day, Year)

MARCH 10 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George M. Breza MD, 912 Seton Drive Cumberland MD 21502

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

John D. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09104

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Martin Hilt

2. Date of Death  
Month Day Year

MARCH 12 1997

3. Time of Death

9:04AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

180-20-7827

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar. 14, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

Somerset

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

R.D. #1, Box 6, Somerset Street

10f. Zip Code

15558

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Music Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Martin William Hilt

18. Mother's Name (First, Middle, Maiden Surname)

Marie Frances Malan

19a. Informant's Name/Relationship (Type, Print)

Phyllis M. Hilt/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RD #1, Box 6, Salisbury, PA 15558

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Salisbury Cem., March 14, 1997

Date

20c. Location - City or Town, State

Salisbury, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Home, Inc.

P. O. Box 116, Salisbury, PA 15558

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

b.

Coronary Artery Disease

Due to (or as a consequence of):

7 years

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D050844

29d. Date signed (Month, Day, Year)

MARCH 12 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jose Loveria, Jr. H.D. 912 Seton Drive Cumberland MD 21502

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

13  
NLSState  
Registrar




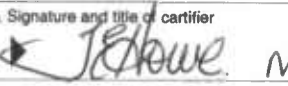

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09105

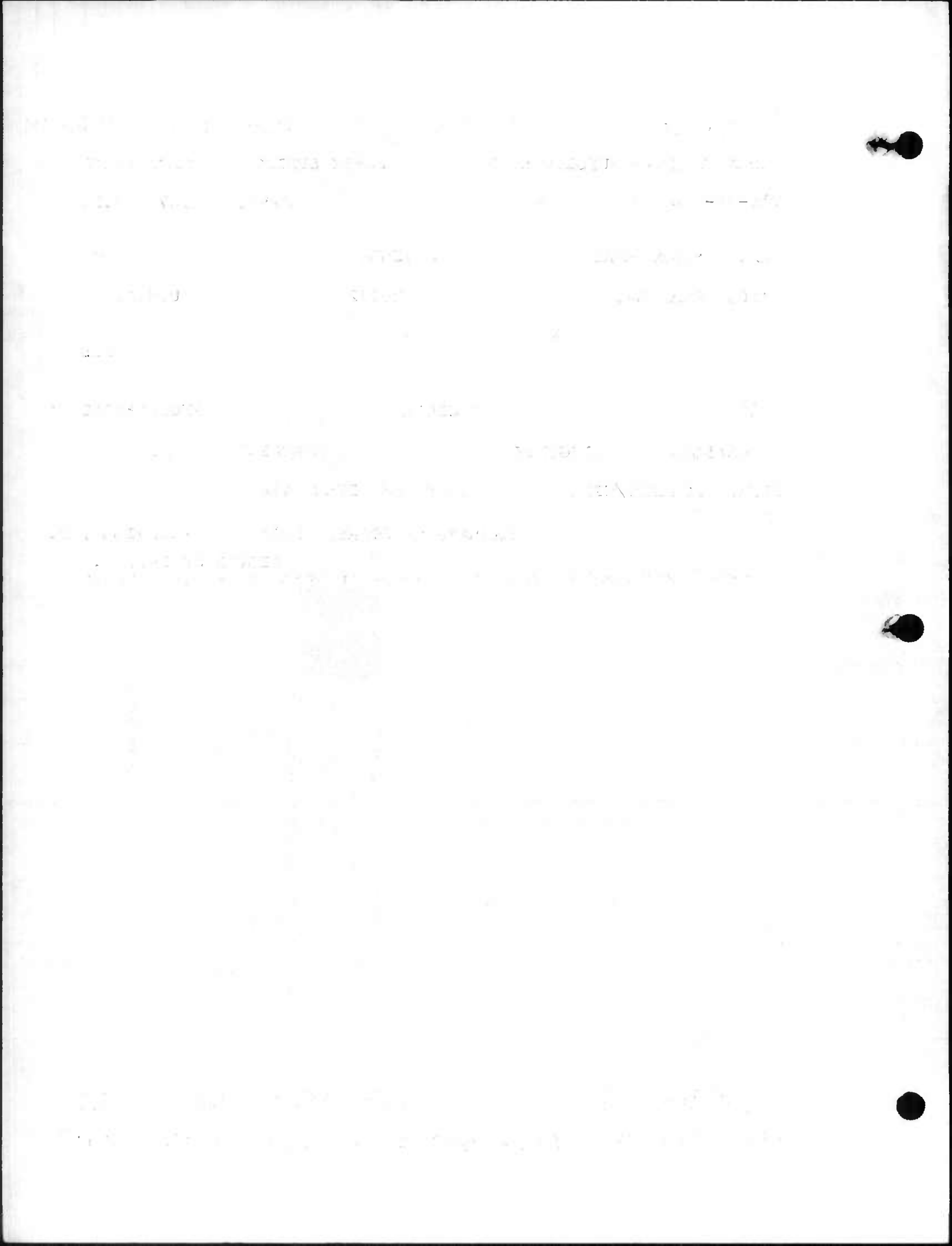
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frederick Haggerty</b>				2. Date of Death Month <b>March</b> Day <b>11</b> Year <b>1997</b>		3. Time of Death <b>8:20 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>BROOKE GROVE NURSING HOME</b>				4b. City, Town, or Location of Death <b>SANDY SPRING</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>216-44-3106</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT. 22, 1907</b>	
	10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>4306 STAR LA.</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ENGINEER</b>		16b. Kind of Business/Industry <b>ENGINEERING</b>			
	17. Father's Name (First, Middle, Last) <b>CHARLES HAGGERTY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HERMAINE CARTIER</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>IRENE HAGGERTY/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKLAWN CEMETERY</b>		Date <b>3/15</b>		20c. Location - City or Town, State <b>ROCKVILLE, MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SILVER SPRING, MD. M00091 CHAMBERS FUNERAL HOMES, P.A. 20910</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPTIC SHOCK</b> Due to (or as a consequence of): <b>b. INTRA - ABDOMINAL INFECTION</b> Due to (or as a consequence of): <b>c. COLON CARCINOMA</b> Due to (or as a consequence of): <b>d.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how Injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>MD</b>				29c. License number <b>ID33700</b>		29d. Date signed (Month, Day, Year) <b>MARCH 11, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ted E. Howe, M.D. 7542 Overlook Dr. Boonsboro, MD 21713</b>								
31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09106

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>LARRY K. HARDY</b>				2. Date of Death Month <b>Mar.</b> Day <b>9,</b> Year <b>1997</b>		3. Time of Death <b>2:10 a.</b>	
4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>238-86-8850</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 11, 1950</b>	
9. Birthplace (State or Foreign Country) <b>N. Carolina</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>#4 Station House Court</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 yrs</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>		16b. Kind of Business/Industry <b>U. S. Government</b>	
17. Father's Name (First, Middle, Last) <b>Robert Hardy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lola Mae Williams</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Betty W. Hardy (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20877 #4 Station House Ct., Gaithersburg, MD</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Brooke Grove Cem.</b>		Date <b>3/13/97</b>		20c. Location - City or Town, State <b>Gaithersburg, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of): b. <b>MULTIPLE ORGAN DYSFUNCTIONAL SYNDROME</b> Due to (or as a consequence of): c. <b>SEPSIS</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death <b>12 days</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Dayashom S MD</b>				29c. License number <b>041119</b>		29d. Date signed (Month, Day, Year) <b>MARCH 10, 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAYA SHARMA 50 W EDMONSTON DRIVE #303 ROCKVILLE MD 20852</b>							
31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

14

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 09107

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eunice Elizabeth HANLON				2. Date of Death Month Day Year March 09, 1997		3. Time of Death 9:30 pm	
	4a. Facility Name (If not institution, give street and number) 5018 Teen Barnes Road				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 071-01-3211		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Sept 2, 1913	
	9. Birthplace (State or Foreign Country) New York		10a. State New York		10b. County Erie		10c. City, Town or Location Grand Island	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3767 East River Road		10f. Zip Code 14072		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Joshua				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth NICHOLS			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Martha G. Roberts				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5018 Teen Barnes Road, Frederick, Maryland 21703			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Date Mar 11, 1997		20d. Location - City or Town, State Smithsburg, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>hepatic failure</u> Due to (or as a consequence of): b. <u>extensive pancreatic CA</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2d 10mo					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D14626		29d. Date signed (Month, Day, Year) March 11, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Gregory Rausch, MD, 501 West Seventh Street, Frederick, Maryland 21701								
31. Date filed (Month, Day, Year) MAR 11 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09108

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRMA VIRGINIA HARRIS

2. Date of Death

MARCH 6, 1997

3. Time of Death

2:27 PM

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

215-20-8990

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 8 1913

9. Birthplace (State or Foreign Country)

md.

Usual Residence of Decedent

10a. State  
MD.10b. County  
FREDERICK10c. City, Town or Location  
ADAMSTOWN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6926 A IRA SEARS RD

10f. Zip Code

21710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10 TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

FAMILY

17. Father's Name (First, Middle, Last)

JOHN FILMORE

18. Mother's Name (First, Middle, Maiden Surname)

MARY ONLEY

19a. Informant's Name/Relationship (Type, Print)

MARY V. HARRIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6926 A IRA SEARS RD ADAMSTOWN MD 21710

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory, or other place)

ST. PAUL UMS CH CEM.

Date

MAR 12 97 DELLA MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME 21701  
100 WEST ALL SAINTS ST FREDERICK MD23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

SEPSIS

Due to (or as a consequence of):

b.

PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

DAYS

DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DECUBITUS ULCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D47556

29d. Date signed (Month, Day, Year)

3/6/97 2:45 PM

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

187 THOMAS JOHNSON DRIVE SUITES, FREDERICK, MD 21702

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09109

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Lee Allen IAGER

2. Date of Death  
Month Day Year

March 9, 1997

3. Time of Death

10:40 PM

4a. Facility Name (If not institution, give street and number)

7303 Glenside Drive

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Prince Georges

5. Social Security Number

215-50-8536

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 04, 1951

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7303 Glenside Drive

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Clyde R. Iager

18. Mother's Name (First, Middle, Maiden Surname)

Treva Fay Hollingsworth

19a. Informant's Name/Relationship (Type, Print)

Treva F. Iager / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7303 Glenside Dr., Takoma Park, MD 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery 3-13-97

Date

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic pancreatic cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George A. Sotos, 9707 Medical Center Dr., #300, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09110

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS LEODA JUDY

2. Date of Death

Month  
MARCHDay  
16Year  
1997

3. Time of Death

05:43

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

212-38-5677A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JUNE 27 1904

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

LAVALLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

421 BRADDOCK STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

ALLEGANY CO BOARD OF EDUCATION

16b. Kind of Business/Industry

TEACHER

17. Father's Name (First, Middle, Last)

WILLIAM W. JUDY

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET I. KEADY

19a. Informant's Name/Relationship (Type, Print)

EARL A. JUDY BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 BRADDOCK STREET LAVALLE, MARYLAND 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLCREST CEMETERY MARCH 19 1997

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME  
404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

14 DAYS

Due to (or as a consequence of):

b. ACUTE PNEUMONIA

14 DAYS

Due to (or as a consequence of):

c. PULMONARY EDEMA &amp; CONGESTIVE HEART FAILURE

14 DAYS

Due to (or as a consequence of):

d. SEVERE AORTIC STENOSIS

720 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chang Hyun Oh, MD

29c. License number

D24951

29d. Date signed (Month, Day, Year)

MARCH 18, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANG HYUN OH, MD. 48 TARN TERRACE, FROSTBURG, MD. 21532

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09111

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>VIRGINIA JACKSON</i>				2. Date of Death Month <i>03</i> Day <i>09</i> Year <i>97</i>		3. Time of Death <i>4 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>MARINER HEALTH CARE BETHESDA</i>				4b. City, Town, or Location of Death <i>BETHESDA</i>		4c. County of Death <i>MONTGOMERY</i>	
Funeral Director	5. Social Security Number <i>579 50 8480</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>95</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Jan. 14, 1902</i>	9. Birthplace (State or Foreign Country) <i>Alexandria, VA.</i>
	Usual Residence of Decedent				10c. City, Town or Location <i>Washington, D.C.</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State		10b. County		10f. Zip Code <i>20011</i>		10g. Citizen of What Country? <i>United States</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic</i>		16b. Kind of Business/Industry <i>Private Homes</i>		
17. Father's Name (First, Middle, Last) <i>George Washington</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Ida Brooks</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Sally M. Washington (Sister In Law)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5510 - 9th St., N.W., Washington, D.C. 20011</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lincoln Memorial Cem.</i>		20c. Location - City or Town, State <i>3/12/97 Suitland, Maryland</i>		
21. Signature of Funeral Service Licensee <i>McGuire E. Heath</i>				22. Name and Address of Facility <i>McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012</i>				
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Pneumonia</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>None</i> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death <i>None</i>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Date of Injury - At home, farm, street, factory, office building, etc. (Specify)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Dr. Schulman M.D.</i>				
29c. License number <i>020516</i>				29d. Date signed (Month, Day, Year) <i>March 12, 1997</i>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Dr. Schulman 9410 Old Georgetown Rd Bethesda 14h 20814</i>				31. Date filed (Month, Day, Year) <i>MAR 13 1997</i>				
32. Registrar's Signature <i>John Davidson-Randall</i>				33. State Registrar <i>3</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09112

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Ethel Bowen Jones</b>				2. Date of Death Month <b>March</b> Day <b>6</b> Year <b>1997</b>		3. Time of Death <b>4:45 PM</b>			
4a. Facility Name (If not institution, give street and number) <b>2505 Glenallen Avenue, #103</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>			
5. Social Security Number <b>577-24-9164</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 3, 1902</b>			
9. Birthplace (State or Foreign Country) <b>Maryland</b>									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <b>2505 Glenallen Avenue, #103</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Skip Tracer</b>		16b. Kind of Business/Industry <b>Law Firm</b>			
17. Father's Name (First, Middle, Last) <b>Agabus H. Bowen, Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Wilson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Virginia J. O'Brien</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>3-7-97</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</b>					
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Cardiorespiratory Arrest</b> Due to (or as a consequence of):  b. <b>Atherosclerotic Heart Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>D20388</b>		29d. Date signed (Month, Day, Year) <b>March 7, 1997</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Howard S. Goldstein, M. D., 4701 Randolph Road, #103, Rockville, MD 20852</b>									
31. Date filed (Month, Day, Year) <b>MAR 10 1997</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

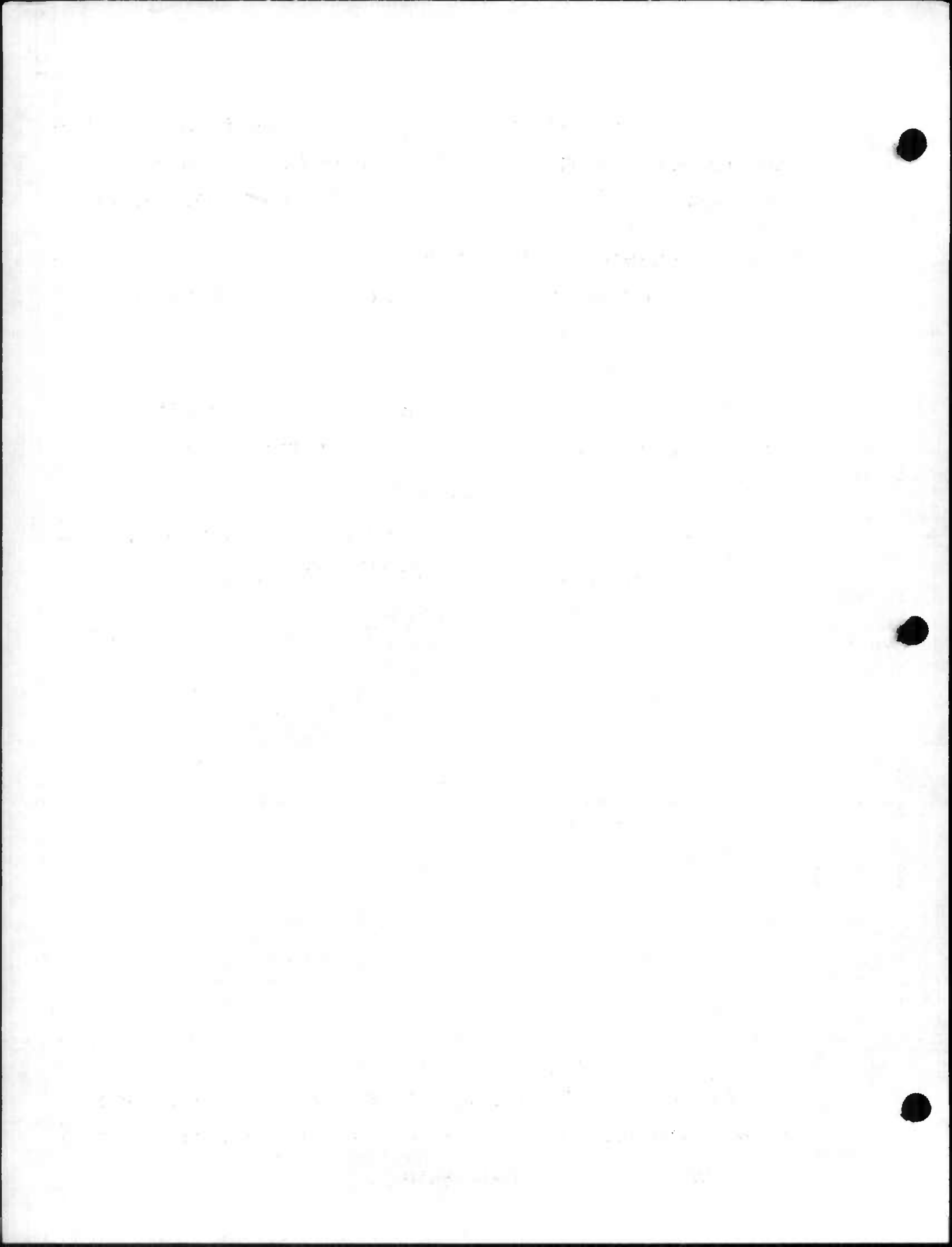
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09113

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE ANTOINETTE JEFFERSON

2. Date of Death

Month  
MARCHDay  
3Year  
1997

3. Time of Death

6:10pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6704 West Forest Road #104

4b. City, Town, or Location of Death

Landover

4c. County of Death

Prince Georges

5. Social Security Number

577-02-3076

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

29

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 1, 1967

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

DC

10b. County

Prince Georges

10c. City, Town or Location

Landover

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6704 W. Forest Rd.

10f. Zip Code

20785

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

unemployed

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

George Jefferson

18. Mother's Name (First, Middle, Maiden Summa)

Doris Whitaker

19a. Informant's Name/Relationship (Type, Print)

Doris Jefferson (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6704 West Forest Rd. #104, Landover, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Glenwood Cemetery

Date

3/7/97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

R. N. Horton

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.  
600 Kennedy Street, NW, Wash., DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration; Anemia; Herpes  
Zoster, varicella; Oral candidiasis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Villanor S. Reyes Jr.

29c. License number

DD9671

29d. Date signed (Month, Day, Year)

3/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Villanor S. Reyes Jr., M.D. 6501 Landover Rd. Chantilly, MD 20785

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09114

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert R. Johnson

2. Date of Death

March 9, 1997

3. Time of Death

5:00 a.m.

4a. Facility Name (If not institution, give street and number)

Manor Care

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-50-8811

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 14, 1906

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

4230 47th Street, N.W.

10f. Zip Code

20016

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Economist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Ole Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Amanda Thorsen

19a. Informant's Name/Relationship (Type, Print)

Edith Johnson, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4230 47th Street, N.W. Washington, DC 20016

20a. Method of Disposition

1X Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Cemetery

Date

3/12/97

20c. Location - City or Town, State

Rockville, MD.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., N.W. Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Broncho Pneumonia

e. Due to (or as a consequence of):

Days

b. Sepsis

b. Due to (or as a consequence of):

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2X No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2X No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4X Nursing Home

5 Residence

8 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

033357

29d. Date signed (Month, Day, Year)

3/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee Jonathan Musher MD 5530 Wisconsin Ave Chevy Chase MD 20815

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09115

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Reco Damarus Lee Jackson				2. Date of Death Month Day Year January 26, 1997				3. Time of Death 8:15 P.M.				
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince Georges				
Funeral Director	5. Social Security Number None	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 42 January 26, 1997	9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince Georges	10c. City, Town or Location Forestville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	10e. Street and Number 6441 Hilmar Drive #201				10f. Zip Code 20747		10g. Citizen of What Country? United States						
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry N/A					
	17. Father's Name (First, Middle, Last) Rodriquez LaVon Jackson				18. Mother's Name (First, Middle, Maiden Surname) Alisa Michelle Lee								
	19a. Informant's Name/Relationship (Type, Print) Alisa Lee				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6441 Hilmar Drive #201, Forestville, MD 20747								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			20c. Location - City or Town, State Beltsville, Maryland						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Fetal Distress Dua to (or as a consequence of):  b. Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 42 Min.		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred N/A			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
29b. Signature and title of certifier 						29c. License number D 16239		29d. Date signed (Month, Day, Year) March 10, 1997					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTONIA K. FOMUFOD, M.D., PGHC DEPT OF PEDIATRICS, MD 20785													
31. Date filed (Month, Day, Year) MAR 12 1997				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

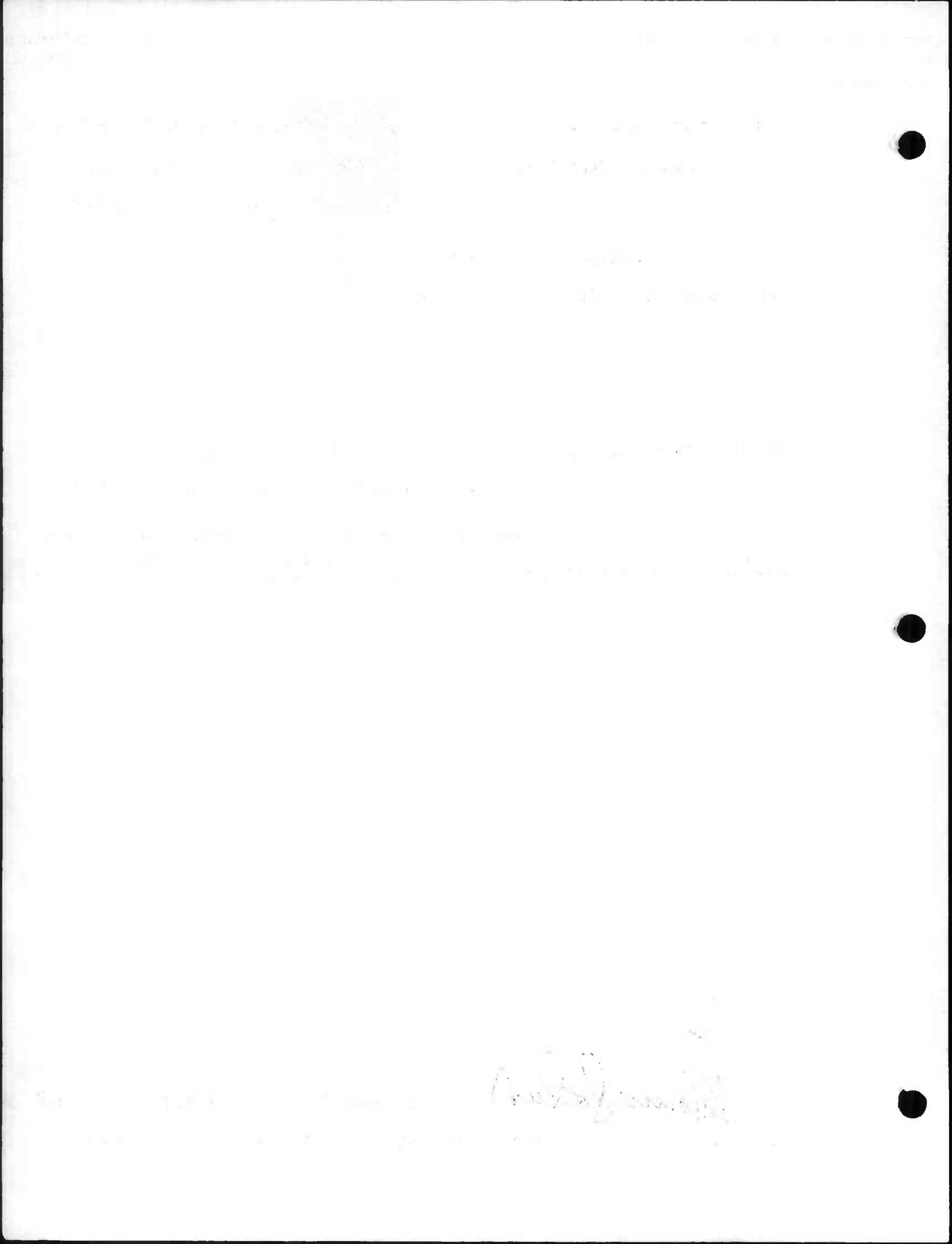
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09116

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MABEL CECILA JOHNSON

2. Date of Death

March 11, 1997

3. Time of Death

3:00 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

13220 Martin Road

4b. City, Town, or Location of Death

Brandywine

4c. County of Death

Prince Georges

5. Social Security Number

213-38-1909

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 22, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13220 Martin Road

10f. Zip Code

20613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

School Principal

16b. Kind of Business/Industry

P.G. Board of Education

17. Father's Name (First, Middle, Last)

Jarrett Lancaster

18. Mother's Name (First, Middle, Maiden Surname)

Irene Robinson

19a. Informant's Name/Relationship (Type, Print)

Joyce Void

Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11415 Kedston Road, Glenn Dale, Maryland 20769-2021

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery

Date

March 14,  
1997

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility

Adams Funeral Home, 20605 Aquasco Road, Aquasco, Maryland 20608

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Cardio Pulm. arrest.

Due to (or as a consequence of):

b.

Multi-infect. dent.

Due to (or as a consequence of):

c.

Fract. of the neck of fem.

Due to (or as a consequence of):

d.

Hypertensi-

Approximate  
Interval Between  
Onset and Death

New

Old.

Old.

Old.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Right above the knee amput.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

K. Danner MD

29c. License number

D25640

29d. Date signed (Month, Day, Year)

3-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Davachi MD 1328 Southern Ave, SE #202 Wash DC 20032

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





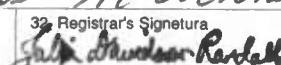
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09117

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Henry Jackson</b>				2. Date of Death Month <b>March</b> Day <b>9</b> Year <b>1997</b>		3. Time of Death <b>6:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>215-32-0980</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04-01-1935</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>912 Carsins Run Road</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Construction/ Self Employed</b>		17. Father's Name (First, Middle, Last) <b>Harry Jackson</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Letitia Devonshire</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Margaret V. Jackson-Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>912 Carsins Run Road, Aberdeen, MD 21001</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gdns</b>		20c. Date <b>3/13/97</b>		20d. Location - City or Town, State <b>Aberdeen, MD</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</b>		23a. Part I. Enter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Acute MI</i></b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>3/13/97</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier 		29c. License number <b>D42800</b>		29d. Date signed (Month, Day, Year) <b>3/10/97</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>T. P. Pardo MD 314 S. Calver Ave, H&amp;B, MD 21078</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>		32. Registrar's Signature 		33. Date of Death (Month, Day, Year) <b>3/13/97</b>		34. Date of Filing (Month, Day, Year) <b>3/10/97</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09118

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Roscoe Jones</b>				2. Date of Death Month Day Year <b>March 5, 1997</b>		3. Time of Death <b>10:03 P.M.</b>	
	4e. Facility Name (If not institution, give street and number) <b>Fredenick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Fredenick</b>		4c. County of Death <b>Fredenick</b>	
Funeral Director	5. Social Security Number <b>178-18-5503</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 9 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Fredenick</b>		10c. City, Town or Location <b>Brunswick</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>117 West "B" Street</b>		10f. Zip Code <b>21716</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carman</b>		16b. Kind of Business/Industry <b>Washington Terminal</b>		17. Father's Name (First, Middle, Last) <b>Joseph A. Jones</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Boyer Jones</b>		19a. Informant's Name/Relationship (Type, Print) <b>Marquerite Jones</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>117 West "B" St. Brunswick, MD 21716</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Brownsville Heights Cemetery Brownsville MD</b>		20c. Location - City or Town, State <b>MD</b>		21. Signature of Funeral Service Licensee <b>Barbara A. Williams, Owner</b>		22. Name and Address of Facility <b>John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716</b>	
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): <b>METASTATIC LUNG DISEASE</b> Due to (or as a consequence of): <b>METASTATIC LIVER DISEASE</b> Due to (or as a consequence of): <b>CORONARY ARTERY BYPASS SURGERY 1984 &amp; 1990</b> <b>PATHOLOGIC FRACTURE RIGHT FEMUR</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>MARCH 5 '97</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred <b>FEMUR BROKE WHILE WALKING</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>117 WEST B ST BRUNSWICK MD</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier <b>Robert R. Roberts MD</b>		29c. License number <b>D09867</b>		29d. Date signed (Month, Day, Year) <b>MARCH 6 1997</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>RRRROBERTS MD 7501 B MCKAIG ROAD FREDERICK MD 21701-3319</b>	
31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>		32. Registrar's Signature <b>[Signature]</b>						

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific requirements for record-keeping. It states that all transactions must be recorded in a timely and accurate manner, and that the records must be maintained for a minimum of five years.

3. The third part of the document discusses the role of the auditor in verifying the accuracy of the records. It states that the auditor must perform a thorough review of the records and must report any discrepancies to the appropriate authorities.

4. The fourth part of the document discusses the consequences of failing to comply with the record-keeping requirements. It states that individuals or organizations that fail to comply may be subject to fines, penalties, or even criminal prosecution.

5. The fifth part of the document discusses the importance of training and education in ensuring compliance with the record-keeping requirements. It states that individuals involved in the financial system must receive appropriate training and education to ensure that they are able to perform their duties accurately and in accordance with the requirements.

6. The sixth part of the document discusses the importance of internal controls in preventing fraud and ensuring the accuracy of the records. It states that organizations must implement effective internal controls to minimize the risk of fraud and to ensure that all transactions are properly recorded.

7. The seventh part of the document discusses the importance of transparency and accountability in the financial system. It states that all transactions must be transparent and that individuals and organizations must be held accountable for their actions.

8. The eighth part of the document discusses the importance of the financial system in the economy. It states that a well-functioning financial system is essential for the growth and development of the economy, and that it is the responsibility of all individuals and organizations to ensure that the system operates effectively and efficiently.

9. The ninth part of the document discusses the importance of the financial system in the lives of individuals. It states that the financial system is essential for the well-being of individuals, and that it is the responsibility of all individuals and organizations to ensure that the system operates effectively and efficiently.

10. The tenth part of the document discusses the importance of the financial system in the future. It states that the financial system will continue to play a vital role in the economy, and that it is the responsibility of all individuals and organizations to ensure that the system operates effectively and efficiently in the future.

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09119

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AUSTIN LAWSON JOY</b>				2. Date of Death Month Day Year <b>MARCH 5, 1997</b>		3. Time of Death <b>4:45 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>ST CATHERINE'S NURSING CENTER</b>				4b. City, Town, or Location of Death <b>EMMITSBURG</b>		4c. County of Death <b>FREDERICK</b>		
Funeral Director	5. Social Security Number <b>220-18-0347</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC. 9, 1905</b>	9. Birthplace (State or Foreign Country) <b>GRACEHAM, MD.</b>	
	Usual Residence of Decedent								
10a. State <b>MARYLAND</b>		10b. County <b>FREDERICK</b>		10c. City, Town or Location <b>EMMITSBURG</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>436 E. MAIN ST.,</b>				10f. Zip Code <b>21727</b>		10g. Citizen of What Country? <b>U. S. A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1925-</b> If Yes, Give Year or Dates: <b>1927</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MAINTENANCE DEPT.</b>		16b. Kind of Business/Industry <b>ST. JOSEPH's college</b>			
17. Father's Name (First, Middle, Last) <b>JOHN THOMAS JOY</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH SUMMERS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>CATHERINE W. JOY</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>436 E. MAIN ST., EMMITSBURG, MD. 21727</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. ANTHONY'S SHRINE</b>		Date <b>3/8/97</b>		20c. Location - City or Town, State <b>EMMITSBURG, MD. 21727</b>		
21. Signature of Funeral Service Licensee <i>John M. Skiles</i>				22. Name and Address of Facility <b>SKILES FUNERAL HOME</b> <b>210 W. MAIN ST., EMMITSBURG, MD. 21727</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Cerebrovascular occlusive Disease</i> Due to (or as a consequence of): b. <i>Carotid artery occlusive Disease</i> Due to (or as a consequence of): c. <i>Arteriosclerosis</i> Due to (or as a consequence of): d. <i>Hypertension</i>									
Approximate Interval Between Onset and Death <i>5 yrs</i> <i>2 yrs</i> <i>15 yrs</i> <i>30 yrs</i>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Costochondritis</i> <i>C-Difficile colitis</i> <i>Herpes Zoster</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			28d. Describe how Injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Bonita Okropfel</i>			29c. License number <b>H 44037</b>		29d. Date signed (Month, Day, Year) <b>6 MARCH 97</b>	
30. Name and address of person who completed cause of death (Item 29e) (Type, Print) <i>Bonita Okropfel, Portier DO, 510 S. Seton Ave. Emmitsburg, MD 21727</i>									
31. Date filed (Month, Day, Year) <b>MAR 06 1997</b>			32. Registrar's Signature <i>John R. Ralston</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09120

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GOLDIE PEARL KREIP

2. Date of Death

Month Day Year  
MARCH 6, 1997

3. Time of Death

14:05 PM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

215-20-6022

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
28-Aug-19

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23 Little Savage Lane

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Solemon Caton

18. Mother's Name (First, Middle, Maiden Surname)

Susan Caton

19a. Informant's Name/Relationship (Type, Print)

Lela Lavin Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20467 National Pike Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frostburg Memorial Park

Date

09-Mar-97

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA  
Due to (or as a consequence of):

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE LUNG DISEASE  
Due to (or as a consequence of):

many years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ POA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

A26907

29d. Date signed (Month, Day, Year)

MARCH 06, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit S. Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, Maryland 21502

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 07 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09121

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM MORRIS KEYSER

2. Date of Death

Month

Day

Year

MARCH

8 1997

3. Time of Death

2130 PM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

705-09-3694

6. Sex

M 20 F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

OCTOBER 15 1906

9. Birthplace (State or Foreign Country)

W.VA.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1X Yes 20 No

10e. Street and Number

8 BROADWAY CIRCLE

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married

3X Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give X

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 2X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

YARD FOREMAN

16b. Kind of Business/Industry

B&amp;O RAILROAD

17. Father's Name (First, Middle, Last)

THOMAS R. KEYSER

18. Mother's Name (First, Middle, Maiden Surname)

NANNIE M. HAWKINS

19a. Informant's Name/Relationship (Type, Print)

BETTY SCOLLOCK

SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

812 LOUISIANA AVE CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1X Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HILLCREST CEMETERY MARCH

Date

11 1997

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EDEMA

Due to (or as a consequence of):

4 days

b. METASTATIC LUNG CANCER

Due to (or as a consequence of):

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1X Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 2X No

26. Place of Death (Check only one)

Hospital: 1X Inpatient 20 ER/Outpatient 30 DOA

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

1X Natural

20 Accident

30 Suicide

40 Homicide

50 Pending investigation

60 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JAMES R. MOEN M.D.

29c. License number

D33417

29d. Date signed (Month, Day, Year)

MARCH 10 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES R. MOEN M.D., 1068 NATIONAL HIGHWAY LAVALLE MD 21502

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

J. R. Moen

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09122

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN Mike KOCHIS

2. Date of Death

MARCH 8 1997

3. Time of Death

6:00 P.M.

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

217-10-7192

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jul 3, 1906

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13502 McMullen Highway

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Texaco

17. Father's Name (First, Middle, Last)

Andrew Kochis

18. Mother's Name (First, Middle, Maiden Surname)

Julia (Czechovich)

19e. Informant's Name/Relationship (Type, Print)

Andrew P. Kochis-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Woodstock, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Ambrose Cemetery

Date

03/12

20c. Location - City or Town, State

Cresaptown, MD

21. Signature of Funeral Service Licensee

James J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home  
Cumberland, MD 21502

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE ASTHMATIC BRONCHITIS

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
Less than one week

More than 30 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James J. Scarpelli MD

29c. License number

D 36766

29d. Date signed (Month, Day, Year)

March 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vik Poonai M.D. 955 Frederick Street Cumberland, MD 21502

31. Date filed (Month, Day, Year)

MAR 10 1997

Registrar's Signature

John Poonai

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09123

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothea M. Kingston

2. Date of Death

March 6 97

Day

Year

3. Time of Death

5:15 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

358-09-7722

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 2, 1913

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3500 Pear Tree Court, #14

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lance Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Anna Anderson

19a. Informant's Name/Relationship (Type, Print)

Merris A. Hollingsworth/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3500 Pear Tree Court, #43, Silver Spring, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

March 10, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.  
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia - Right Lung  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Type II IDDM. Poorly controlled

Malnutrition, stress

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael A. Davidson M.D.

29c. License number

D01388

29d. Date signed (Month, Day, Year)

March 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael R. Davidson M.D.

13975 Connecticut Ave Silver Spring MD 20906

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

97 09124

Amended #19b., 3/17/97, GF, Montg. Co.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosalie R. Kennedy						2. Date of Death Month Day Year March 9, 1997		3. Time of Death 2:30 P.M.	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital						4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-16-1177		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 22, 1917		9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 12202 Hunters Lane				10f. Zip Code 20852		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator			16b. Kind of Business/Industry D.C. Public Schools				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frank S. Reid						18. Mother's Name (First, Middle, Maiden Surname) Mary E. Royce			
	19a. Informant's Name/Relationship (Type, Print) James H. Kennedy (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2939 Van Ness Street, N.W., #1020 Washington, D.C. 20008					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cemetery		20c. Location - City or Town, State Suitland, Maryland					
	21. Signature of Funeral Service Licensee Thomas G. Clyburn				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. DIFFUSE ATHEROSCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death UNKNOWN	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier M. M. M. MD				29c. License number D 41662		29d. Date signed (Month, Day, Year) MARCH 9, 1997			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SABED KHOWFLI MD 40 SUBURBAN HOSPITAL									
	31. Date filed (Month, Day, Year) MAR 13 1997				32. Registrar's Signature John Davidson-Randall					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09125

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MAN HO KIM</b>				2. Date of Death Month <b>March</b> Day <b>9</b> Year <b>1997</b>		3. Time of Death <b>9:15 pm</b>				
	4e. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY COUNTY</b>				
Funeral Director	5. Social Security Number <b>217-43-9903</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>1/18/18</b>				
	9. Birthplace (State or Foreign Country) <b>KOREA</b>		10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>				
Usual Residence of Decedent											
10a. State <b>MD</b>			10b. County <b>MONTGOMERY</b>			10c. City, Town or Location <b>SILVER SPRING</b>					
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>14143 Castle Boulevard, #304</b>			10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>KOREA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Man</b>			16b. Kind of Business/Industry <b>Private</b>					
17. Father's Name (First, Middle, Last) <b>Myoung Kim</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Dae Yoo</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Sung Kim (son)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14143 Castle Blvd, #304 Silver Spring, MD 20904</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>			Data <b>3/11/97</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>			
21. Signature of Funeral Service Licensee <i>Alexander S. Pope Jr.</i>					22. Name and Address of Facility <b>Pope Funeral Homes, Silver Spring, MD 11315 Lockwood Drive, Silver Spring, MD</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): b. <b>PNEUMONIA</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>1 DAY</b> <b>1 DAY</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTI-INFARCT DEMENTIA</b>									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)			28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>Steven T. Kariya MD</i>			29c. License number <b>D36252</b>		29d. Date signed (Month, Day, Year) <b>MARCH 09, 1997</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>STEVEN T. KARIYA, MD, 11201 GEORGIA AVE #575, WHEATON MD 20902</b>											
31. Date filed (Month, Day, Year) <b>MAR 13 1997</b>			32. Registrar's Signature <i>Lidia Davidson-Randall</i>								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09126

ITEM:10b,c,e,f per FH G-747 5-1-97 eoh

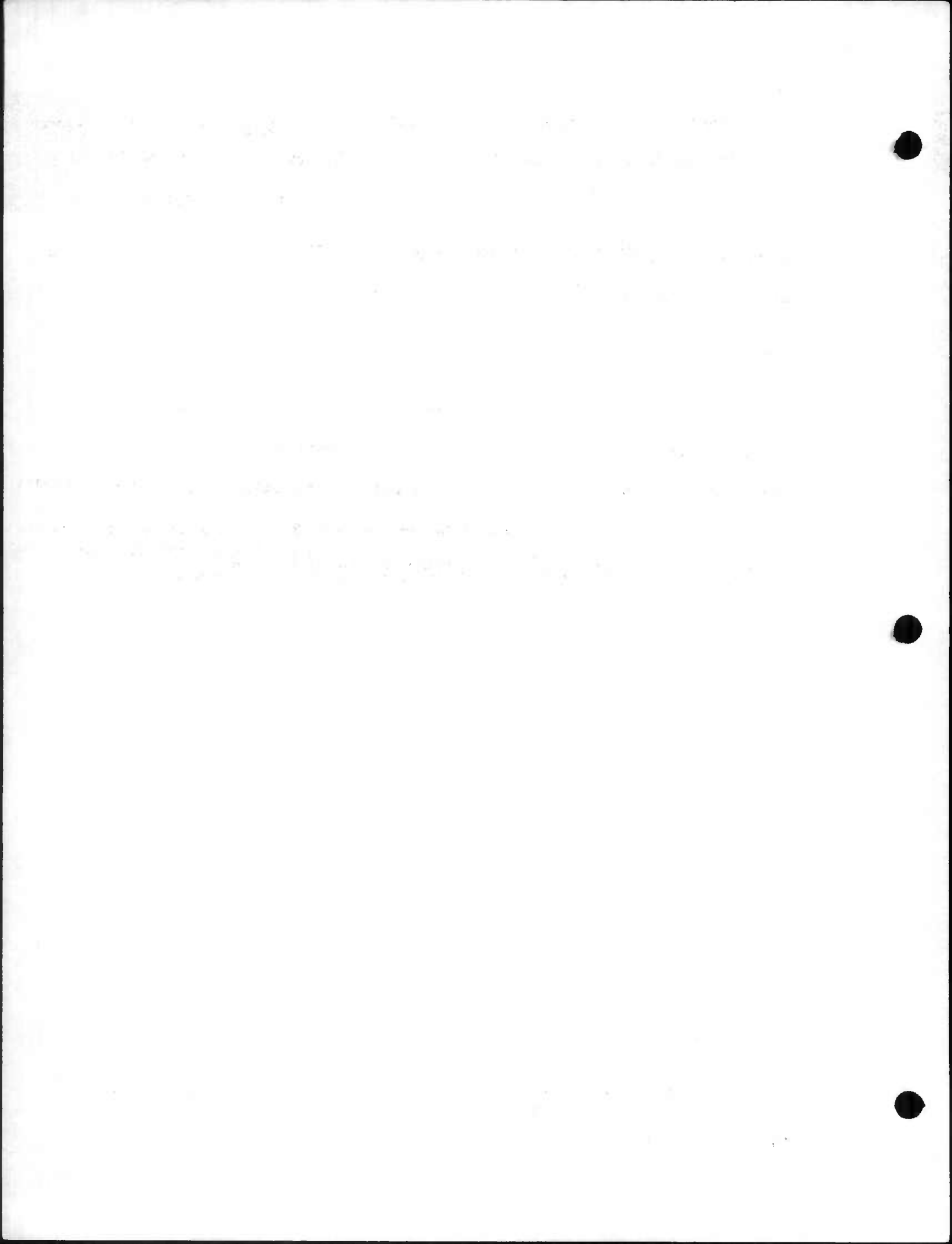
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jeung Soon Kim</i>			2. Date of Death Month: <i>March</i> Day: <i>6</i> Year: <i>1997</i>		3. Time of Death <i>7:45 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Doctors Community Hospital</i>			4b. City, Town, or Location of Death <i>Lanham</i>		4c. County of Death <i>Prince Georges</i>	
Funeral Director	5. Social Security Number <i>N/A</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>79</i> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <i>Mar. 28, 1917</i>	9. Birthplace (State or Foreign Country) <i>Korea</i>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>PRINCE GEORGES Montgomery</i>	10c. City, Town or Location <i>Silver Spring</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10a. Street and Number <i>6412 AUBURN AVE 22 Castle Cliff Court</i>		10f. Zip Code <i>20737 20904</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <i>9</i> College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>		16b. Kind of Business/Industry <i>Domestic</i>		
Physician /Medical Examiner	17. Father's Name (First, Middle, Last) <i>Unobtainable</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Unobtainable</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Thomas C. Kim / Son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>22 Castle Cliff Court, Silver Spring, Maryland 20904</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery</i>		20c. Location - City or Town, State <i>3/8/97 Silver Spring, Maryland</i>		
	21. Signature of Funeral Service Licensee <i>Seni Short-Helland</i>		22. Name and Address of Facility <i>Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</i>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
	Immediate Cause (Final disease or condition resulting in death) a. <i>Massive Cerebral bleeding</i> Due to (or as a consequence of):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>Hypertension</i> Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>Jeung Soon Kim MD</i>		29c. License number <i>D-19250</i>		29d. Date signed (Month, Day, Year) <i>3-6-97</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>9470 Annapolis Rd. Lanham, MD. 20706</i>						
	31. Date filed (Month, Day, Year) <i>MAR 12 1997</i>		32. Registrar's Signature <i>Julia Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09127

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRENE

ANNE

KRICUN

2. Date of Death

Month Day Year  
MARCH 8, 1997

3. Time of Death

3:20 A.M.

4e. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

12/9/1914

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1111 UNIVERSITY BLVD. WEST # 1309

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

ISIDORE

GELBERG

18. Mother's Name (First, Middle, Maiden Surname)

ROSE FINKELSTEIN

19e. Informant's Name/Relationship (Type, Print)

STUART L. KRICUN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1810 MALCOLM AVENUE # 103 LOS ANGELES, CA 90025

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

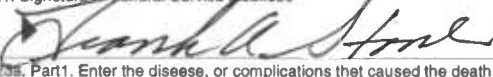
JUDEAN MEMORIAL GARDENS 3/10/97

Date

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicidal 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D08546

29d. Date signed (Month, Day, Year)

MARCH 10, 1997

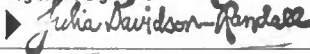
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN F. TAUBER, M.D. 8218 WISCONSIN AVENUE BETHESDA, MARYLAND 20814

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09128

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Platonias Papps Kirkwood

2. Date of Death

Month Day Year  
March 5, 1997

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-38-1965

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 20, 1914

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5611 Newington Road

10f. Zip Code

20816

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Administrative Law Judge for  
the National Labor Relations

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Ernest Papps

18. Mother's Name (First, Middle, Maiden Surname)

Iphigenia Maktos

19a. Informant's Name/Relationship (Type, Print)

Paul P. Kaldes/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9401 Falls Bridge Lane Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

3/8/97

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Jeffrey A. Papp

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.  
5130 Wisconsin Avenue, NW  
Washington, D.C. 2001623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE ANTERIOR MYOCARDIAL INFARCTION

Due to (or as a consequence of):

4 MRS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

4 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Roger Stevenson, Jr.

29c. License number

D-20535

29d. Date signed (Month, Day, Year)

3/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROGER STEVENSON, JR. M.D. 6410 ROCKLEDGE DR #200 BETHESDA, MD

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

Lia Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

40



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09129

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DIANN ROBECCA Kremer

2. Date of Death

March 10 1997

Day Year

3. Time of Death

2:30pm

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

277-74-9529

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 8, 1949

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9041 Early April Way

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

None

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

William Kremer

18. Mother's Name (First, Middle, Maiden Surname)

Ruby A. Sowell

19a. Informant's Name/Relationship (Type, Print)

Clyde Sowell Uncle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

604 Bryan Point Rd., Accokeek, Maryland 20607

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Memorial Gardens

Date

March 13, 1997

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Wally Williams

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A.

4270 Hawthorne Rd., Indian Head, Maryland 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Anoxic Encephalopathy

Due to (or as a consequence of):

b. Seizure disorder

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 days

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Laxmi N. Berwa, M.D.

29c. License number

D-24535

29d. Date signed (Month, Day, Year)

3/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi N. Berwa, M.D. 7700 Old Branch Ave., Clinton, MD

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09130

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Herman Lee</b>				2. Date of Death Month <b>MARCH</b> Day <b>9</b> Year <b>1997</b>		3. Time of Death <b>2200</b>		
	4a. Facility Name (If not institution, give street and number) <b>Dorchester General Hosp.</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>		
Funeral Director	5. Social Security Number <b>220-10-6328</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12-26-15</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>710-LEONARD'S Lane</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Trainer</b>			16b. Kind of Business/Industry <b>Race Track</b>		
	17. Father's Name (First, Middle, Last) <b>Will Lee</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary James</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Sandra Ennels</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>724-Douglas Street Cambridge Maryland 21613</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bethel Cemetery</b>		Date <b>3/15/97</b>		20c. Location - City or Town, State <b>Cambridge, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Janelle C. Henry</b>				22. Name and Address of Facility <b>HENRY Funeral Home 510 Washington St. Cambridge, Maryland 21613</b>				
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiac Arrhythmia</b> Due to (or as a consequence of): b. <b>Respiratory failure</b> Due to (or as a consequence of): c. <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>3 minutes</b> <b>2 weeks</b> <b>20 years</b>								
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>pneumonia</b> <b>congestive heart failure</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Mark Markus</b>		29c. License number <b>D0050804</b>		29d. Date signed (Month, Day, Year) <b>3/16/97</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mark Markus, MD 408 Byrn Street, Cambridge, MD 21613</b>									
31. Date filed (Month, Day, Year) <b>MAR 13 1997</b>		32. Registrar's Signature <b>Jill Davidson-Randall</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Amended #1, 3/6/97, M.D., Allegany County

97 09131

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT EDWARD LIKENS JR. Sr.</b>				2. DATE OF DEATH MONTH <b>03</b> DAY <b>03</b> YEAR <b>97</b>		3. TIME OF DEATH <b>3:00 P.M.</b>					
4. SOCIAL SECURITY NUMBER <b>214-28-7166</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 13, 1932</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>19207 Shaft Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frostburg</b>				9c. COUNTY OF DEATH <b>Allegany</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Frostburg</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>19207 Shaft Road</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (13-16 or 17+) <b>0</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Country Club</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Wm. E. Likens</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nettie Elkins</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Patsy Likens</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19207 Shaft Road, Frostburg, Md. 21532</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Mem. Park March 6, 1997</b>		20c. LOCATION — City or Town, State <b>Cumberland, Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James E. McKee</b>				22. NAME AND ADDRESS OF FACILITY <b>Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction, less than one hour.</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Coronary Artery Disease with hist. of M.I.</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death: <b>45 years</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus.</b> <b>COPD</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Chang Hyun Oh, M.D.</b>				29c. LICENSE NUMBER <b>D24951</b>				29d. DATE SIGNED (Month, Day, Year) <b>03/05/97</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Chang Hyun Oh, M.D., 48 Tarn Terrace, Suite 204, Frostburg, Md. 21532</b>											
31. DATE FILED (Month, Day, Year) <b>MAR 06 1997</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97-09132

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARLTON WARD LEWIS Sr.

2. Date of Death

MARCH 4, 1997

3. Time of Death

6:42 AM

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

216-22-6006

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

AUG. 23, 1997

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7958 McKaig Road

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

State Police Officer

16b. Kind of Business/Industry

State Government

17. Father's Name (First, Middle, Last)

Harold T. Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Mary Frances Wilt

19a. Informant's Name/Relationship (Type, Print)

Dorothy J. Lewis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7958 McKaig Road, Frederick, MD 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Crematory

Date

3/5/97

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Ernest A. Riley, Jr.

22. Name and Address of Facility

Leasure-Stein, Inc., 230 Baltimore Avenue  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE CARDIO MEGALY

Due to (or as a consequence of):

INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ACUTE AND SUBACUTE MYOCARDIAL

Due to (or as a consequence of):

1-10 days

c. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George I. Smith, Jr. M.D.

29c. License number

D 10587

29d. Date signed (Month, Day, Year)

May 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE I. SMITH, JR. MD VPM 400 W. 7th St., Frederick, MD 21701

31. Date filed (Month, Day, Year)

JUN 11 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09133

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MINA LEWIS</b>				2. Date of Death Month <b>March</b> Day <b>4</b> Year <b>1997</b>		3. Time of Death <b>7:45 pm</b>	
	4e. Facility Name (If not institution, give street and number) <b>Mediplus of Montgomery Village Gaithersburg</b>				4b. City, Town, or Location of Death <b>Montgomery</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>133-10-1581</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 25, 1904</b>	
	9. Birthplace (State or Foreign Country) <b>N.Y.</b>		10a. State <b>md.</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>19301 Watkins Mills Rd</b>		10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Board of Education</b>			
	17. Father's Name (First, Middle, Last) <b>Israel Feinsinger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rebecca Neidstadt</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Barbara O'Brien (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 Foxwood Ct Germantown, Md 20876</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. COMFORT CREMATORY</b>		20c. Location - City or Town, State <b>3/6/97 ALEXANDRIA, VIRGINIA</b>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Mark L. Villalta</b>				22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Chronic Renal Failure</b> Due to (or as a consequence of): <b>Hypertensive Heart Disease</b> Due to (or as a consequence of): <b>Hypertension, Chronic</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>H. Robert Birschbach MD</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>504115</b>				29d. Date signed (Month, Day, Year) <b>March 4, 1997</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>H. ROBERT BIRSCHBACH MD 6320 Democracy Blvd Bethesda Md 20817</b>				31. Data filed (Month, Day, Year) <b>MAR 12 1997</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>Julia Davidson-Randall</b>				33. State Registrar			
	34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020				35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09134

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

NADINE C. LUDWIG

2. Date of Death  
Month Day Year

MARCH 6, 1997

3. Time of Death

6:40 PM

4a. Facility Name (If not institution, give street and number)

Potomac Valley Nursing &amp; Wellness Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

565-14-9265

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 14, 1911

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11711 Leona Street

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Real Estate Agent

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

George N. Thornton

18. Mother's Name (First, Middle, Maiden Surname)

Georgia Mae Meade

19a. Informant's Name/Relationship (Type, Print)

Marlow B. Ludwig

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11711 Leona Street Wheaton, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3/10/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Eric S. Scerbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

1

b. Atherosclerotic Heart Disease

Due to (or as a consequence of):

10 Yrs.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia-Alzheimer's Type

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41931

29d. Date signed (Month, Day, Year)

March 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

R. Shumacher, M.D. 2309 Shorefield Road Wheaton, Maryland 20902-1825

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09135

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR HENCH LAMBERT

2. Date of Death

Month Day Year  
March 10, 1997

3. Time of Death

1:50 PM

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

219-36-4025

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 8, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

Rosemont Avenue

Citizens Nursing Home

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Circuit Court

17. Father's Name (First, Middle, Last)

George H. Lambert

18. Mother's Name (First, Middle, Maiden Surname)

Lydia M. Baer

19a. Informant's Name/Relationship (Type, Print)

Robert A. Lambert/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9328 White Rock Avenue, Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Olivet Cemetery

Date

3/13

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST., FREDERICK, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Congestive Heart Failure

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D09689

29d. Date signed (Month, Day, Year)

March 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A. Austin Pearre Jr., MD 300 West Ninth Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

22.3.18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09136

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORA LEE LAKE				2. Date of Death Month: MARCH 3, Day: 1997, Year: 1997		3. Time of Death 9:11 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 219-14-7992		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Mar 5 1925	
	9. Birthplace (State or Foreign Country) Lovetttsville VA		10a. State MD		10b. County Frederick		10c. City, Town or Location Jefferson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4229 Springview Court		10f. Zip Code 21755		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Processor		16b. Kind of Business/Industry State Farm Ins Co.			
	17. Father's Name (First, Middle, Last) Charles D. Green				18. Mother's Name (First, Middle, Maiden Surname) Pearl M. Cummings			
	19a. Informant's Name/Relationship (Type, Print) Audrey L. Dixon				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4229 Springview Ct. Jefferson MD 21755			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Edge Hill Cemetery		Date 3/6/97		20c. Location - City or Town, State Charles Town WV	
	21. Signature of Funeral Service Licensee Barbara H. Williams, Owner		21. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular disease							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier Christopher Fleming				29c. License number 037178		29d. Date signed (Month, Day, Year) 3-3-97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 Ninth Avenue, Brunswick, MD 21716							
31. Date filed (Month, Day, Year) 3 - MAR 10 7 1997				32. Registrar's Signature John D. Anderson				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09137

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS JOSEPH McATEER				2. Date of Death Month Day Year MARCH 6 1997		3. Time of Death 7:55 A.M.		
	4a. Facility Name (If not institution, give street and number) 100 HONEYSUCKLE LANE				4b. City, Town, or Location of Death FROSTBURG		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 218 09 5459		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	8. Date of Birth (Month, Day, Year) FEB 4, 1921		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location FROSTBURG		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 100 HONEYSUCKLE LANE				10f. Zip Code 21532		10g. Citizen of What Country? U.S.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER		16b. Kind of Business/Industry CONTRACTING		
	17. Father's Name (First, Middle, Last) OWEN C. McATEER				18. Mother's Name (First, Middle, Maiden Surname) MARGARET GREENE				
	19a. Informant's Name/Relationship (Type, Print) OWEN McATEER/BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERWOOD ROAD, UPPER FALLS, MD 21156				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MICHAEL'S CEMETERY		Date 3/9/97		20c. Location - City or Town, State FROSTBURG, MD 21532		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death UNKNOWN YEARS								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D09157		29d. Date signed (Month, Day, Year) MARCH 6, 1997		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PAUL SNOW, M.D., 124 W. 3RD ST., CUMBERLAND, MD 21502	
31. Date filed (Month, Day, Year) MAR 10 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09138

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene C. Morin

2. Date of Death

Month Year  
MARCH 6 1997

3. Time of Death

16:00

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

220-16-6789

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Mar 30, 1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1304 Kentucky Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Production Manager

16b. Kind of Business/Industry

Queen City Brewing Co.

17. Father's Name (First, Middle, Last)

Harry C. Morin

18. Mother's Name (First, Middle, Maiden Surname)

Anna M. (Main)

19a. Informant's Name/Relationship (Type, Print)

Ann C. Morin-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1304 Kentucky Avenue Cumberland MD 21502

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Mary's Cemetery

Date

03/10

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home  
Cumberland, MD 2150223a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. Alzheimer's Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 days

7 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

Seizures

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas E. Chappell

29c. License number

D 35135

29d. Date signed (Month, Day, Year)

MARCH 7/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Evan Chappell m 912 Seton Dr. Cumberland MD

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09139

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES EDWARD MCDONALD</b>				2. Date of Death Month <b>MARCH</b> Day <b>8</b> Year <b>1997</b>				3. Time of Death <b>0145 AM</b>										
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>				4c. County of Death <b>ALLEGANY</b>										
Funeral Director	5. Social Security Number <b>220-10-4603</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUL 27, 1911</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>										
	Usual Residence of Decedent																		
10a. State <b>MARYLAND</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>LAVALE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number <b>12 MCKENZIE ROAD</b>				10f. Zip Code <b>21502</b>				10g. Citizen of What Country? <b>USA</b>											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF-EMPLOYED CONTRACTOR</b>				16b. Kind of Business/Industry <b>CONSTRUCTION</b>											
17. Father's Name (First, Middle, Last) <b>GEORGE MCDONALD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ALICE GARLITZ</b>															
19a. Informant's Name/Relationship (Type, Print) <b>MRS. AUDREY MCDONALD</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 MCKENZIE RD LAVALE, MD 21502</b>															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ECKHART CEMETERY</b>				20c. Location - City or Town, State <b>MARCH 11, 1997 ECKHART, MD</b>											
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HAVER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502</b>															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td rowspan="4">}</td> <td>e. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):</td> <td><b>1 week</b></td> </tr> <tr> <td>b. <b>DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of):</td> <td><b>5 years</b></td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	}	e. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):	<b>1 week</b>	b. <b>DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of):	<b>5 years</b>	c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	}	e. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):	<b>1 week</b>																
		b. <b>DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of):	<b>5 years</b>																
		c. Due to (or as a consequence of):																	
		d. Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PNEUMONITIS</b>																			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 				29c. License number <b>D33417</b>		29d. Date signed (Month, Day, Year) <b>MARCH 10 1997</b>													
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JAMES R. MOEN M.D., 1068 NATIONAL HIGHWAY LAVALE, MD 21502</b>																			
31. Date filed (Month, Day, Year) <b>MAR 10 1997</b>				32. Registrar's Signature 															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

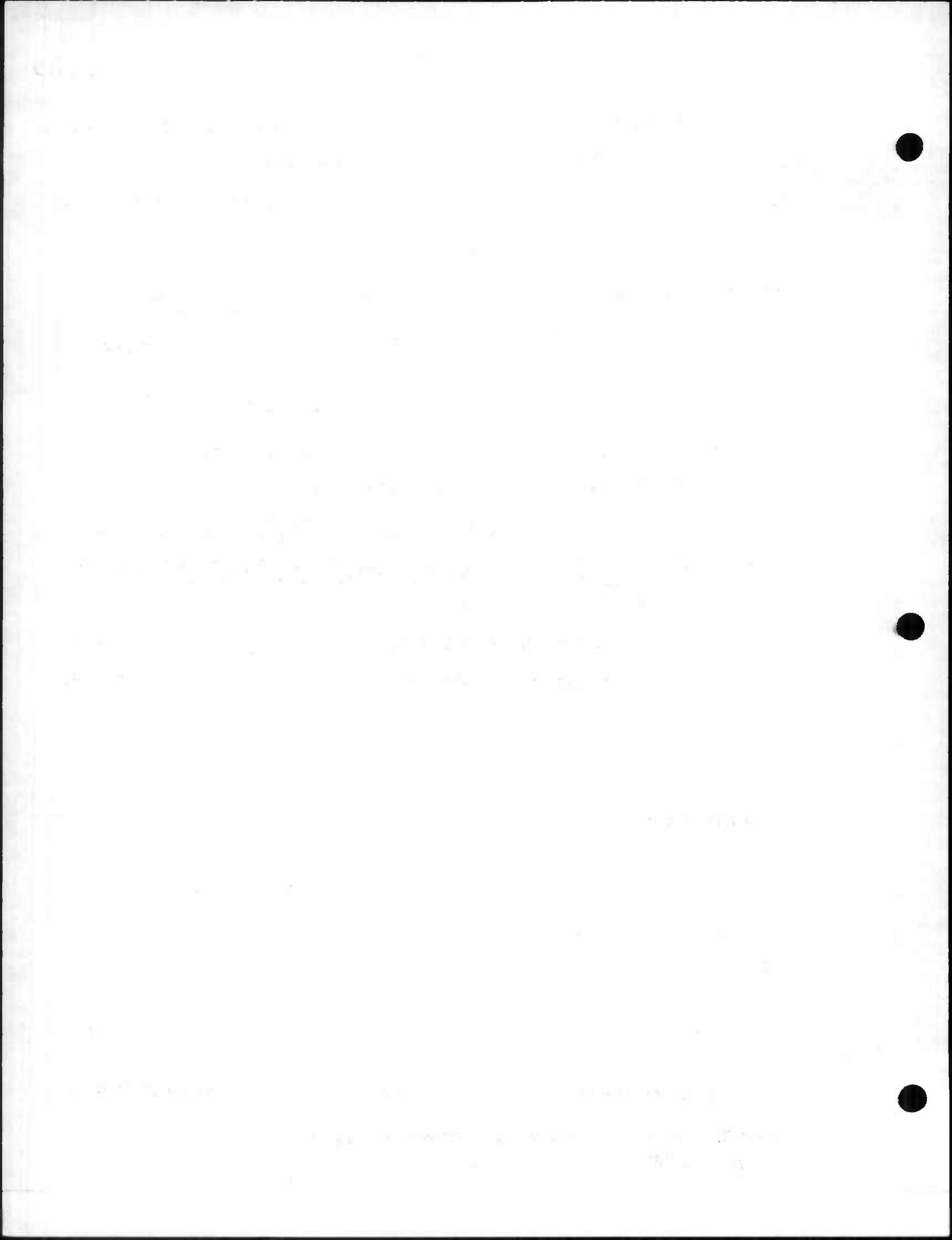
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09140

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT FRANKLIN MOWRY

2. Date of Death

March 10, 1997

3. Time of Death

7:10PM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

5. Social Security Number

206-07-1140

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 11, 1914

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

ELLERSLIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

P. O. BOX 144

10f. Zip Code

21529

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

CORPORATE

17. Father's Name (First, Middle, Last)

FRANKLIN LEWIS MOWRY

18. Mother's Name (First, Middle, Maiden Surname)

IDA MAUDE LAMBERT

19a. Informant's Name/Relationship (Type, Print)

LOIS WAGNER/ NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5431 KING ARTHUR CIRCLE, BALTIMORE, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

RESTLAWN MEM. PARK MARCH 14, 1997 LAVALE, MD 21502

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARVEY H. ZEIGLER FUNERAL HOME  
HYNDMAN, PA 15545-063623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia

Due to (or as a consequence of):

2 Weeks

b. Alzheimer's Disease

Due to (or as a consequence of):

4 Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastc. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D20215

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARMACHANDRA NAIR, M.D., VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09141

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lena Frances Mulcahy

2. Date of Death

Month Day Year  
MARCH 10 1997

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Alleg.

Funeral  
Director

5. Social Security Number

235-82-4888

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
8-16-37

9. Birthplace (State or Foreign Country)

Wv.

Usual Residence of Decedent

10a. State

Wv.

10b. County

Mineral

10c. City, Town or Location

Piedmont

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

51 Jones St.

10f. Zip Code

26750

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Arthur K. Decker

18. Mother's Name (First, Middle, Maiden Surname)

Gladys M. Grapes

19a. Informant's Name/Relationship (Type, Print)

John O. Hanlin Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 148 Westernport, Md. 21562

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Potomac Memorial Gard.

Date

2-13

20c. Location - City or Town, State

Keyser, Wv.

21. Signature of Funeral Service Licensee

William H. Fredlock III

22. Name and Address of Facility

Fredlock F.H. 31 Jones St. Piedmont, Wv.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.e. METASTATIC CARCINOMA LUNG  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Two yrs.

Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Rheumatoid Arthritis.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

H. Sidi

29c. License number

D26907

29d. Date signed (Month, Day, Year)

MARCH 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Hajit Sidhu 925 Bishop Walsh Rd. Cumberland, Md. 21502

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John H. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2  
HLS





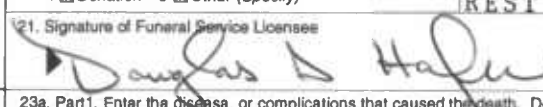
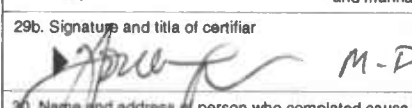
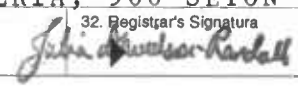
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09142

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VADA CATHERINE METZ				2. Date of Death Month Day Year MARCH 11 1997		3. Time of Death 14:34	
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 220-32-4751		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) DEC 13, 1908	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location RAWLINGS	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 18708 MC MULLEN HWY		10f. Zip Code 21557		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) GEORGE HENRY LOAR				18. Mother's Name (First, Middle, Maiden Surname) MANDANNA LOAR			
	19a. Informant's Name/Relationship (Type, Print) JAMES W. METZ				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 EDNOR RD, BALTIMORE, MD 21218			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) REST LAWN MEMORIAL GARDENS		20c. Date MAR 15, 1997		20d. Location - City or Town, State LA VALE, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LA VALE, MD 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. SEVERE GASTROINTESTINAL BLEEDING Due to (or as a consequence of): b. PEPTIC ULCER DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1-2 DAYS UNKNOWN							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  M.D.		29c. License number D50844		29d. Date signed (Month, Day, Year) MARCH 14, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOSE LOUVERIA, 900 SETON DRIVE, CUMBERLAND, MD 21502								
31. Date filed (Month, Day, Year) MAR 17 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09143

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ADA E. MORRIS				2. Date of Death Month Day Year March 6, 1997		3. Time of Death 5:45 P.M.			
	4a. Facility Name (If not institution, give street and number) Independence Court Hyattsville				4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 577 12 7276	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 9, 1903		9. Birthplace (State or Foreign Country) New York, N.Y.		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Hyattsville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 5821 Queens Chapel Rd.				10f. Zip Code 20782		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry U.S. Government					
	17. Father's Name (First, Middle, Last) Unavailable				18. Mother's Name (First, Middle, Maiden Surname) Mary Unavailable					
	19a. Informant's Name/Relationship (Type, Print) Lucille Carr (Cousin)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5353 Chillum Pl., N.E., Washington, D.C. 20011					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 3/11/97		20c. Location - City or Town, State Landover, MD.					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <b>CARDIAC ARREST</b> Due to (or as a consequence of): b. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>IMMEDIATE</b> <b>20 YEARS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number D23127		29d. Date signed (Month, Day, Year) March 10, 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kevin G. Nealon, M.D., 5530 Wisconsin Ave., #925, Chevy Chase, Maryland 20815										
31. Date filed (Month, Day, Year) MAR 12 1997			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



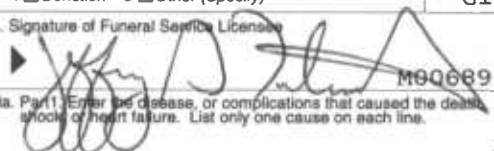

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09144

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret E. Mahaney				2. Date of Death Month Day Year MAR 9 1997		3. Time of Death 8:20 AM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579 07 1560		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 24, 1910	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4011 Randolph Road		10f. Zip Code 20902		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Lewis C. Winters				18. Mother's Name (First, Middle, Maiden Surname) Rose Hagerty			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sally Keen/ Executrix				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 557, Garrett Park, Maryland 20896			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Piece of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		20c. Location - City or Town, State Washington, D.C.		20d. Date March 12, 1997	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee  M90689				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
	23a. Part I: Enter the disease, or complications that caused the death, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>aspiration pneumonia</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23c. Part II: Enter the disease, or complications that caused the death, shock of heart failure. List only one cause on each line. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Congestive heart failure</i>				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  M.D.		29c. License number D09834	
	29d. Date signed (Month, Day, Year) 3/9/97		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BARRY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON, MD 20885		31. Date filed (Month, Day, Year) MAR 12 1997		32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09145

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John L. Michalak

2. Date of Death

March 6 1997

3. Time of Death

2:40 AM

4a. Facility Name (If not institution, give street and number)

5117 Flanders Avenue

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

236-03-7877

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 6, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5117 Flanders Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1941-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineering Technician

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Joseph Michalak

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Tedla

19a. Informant's Name/Relationship (Type, Print)

Helen H. Michalak

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5117 Flanders Avenue Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery 3/10/97 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Eric S. Scarbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinomatosis Diffuse

Due to (or as a consequence of):

Indef

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis C. Mayle, M.D.

29c. License number

D 07099

29d. Date signed (Month, Day, Year)

March 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis C. Mayle, M.D. 10215 Fernwood Road Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09146

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT

2. Date of Death

Month Day Year  
MAR 6 97

3. Time of Death

8:54 A

4e. Facility Name (If not institution, give street and number)

3309 Cummings Lane

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

025-20-6286

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 1, 1928

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3309 Cummings Lane

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+) 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

James H. Meisel

18. Mother's Name (First, Middle, Maiden Surname)

Anna Rosenbusch

19a. Informant's Name/Relationship (Type, Print)

Jean M. Meisel / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3309 Cummings Lane, Chevy Chase, Maryland 20815

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

March 8, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

ACUTE

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

INTER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis C. Mayle

29c. License number

DOY099

29d. Date signed (Month, Day, Year)

MARCH 6 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20814

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09147

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Thomas William McGuire

2. Date of Death

Month Day Year  
03 11 97

3. Time of Death

6:40 AM

4a. Facility Name (If not institution, give street and number)

St. Catherines Nursing Center

4b. City, Town, or Location of Death

Emmitsburg

4c. County of Death

Frederick

5. Social Security Number

577-09-8994

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 29, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA

10b. County

Adams

10c. City, Town or Location

Gettysburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

258 Lane Avenue

10f. Zip Code

17325

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Projectionist

16b. Kind of Business/Industry

Motion Pictures

17. Father's Name (First, Middle, Last)

Martin McGuire

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Curran

19a. Informant's Name/Relationship (Type, Print)

Mary Jane McGuire

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

258 Lane Avenue, Gettysburg, PA 17325

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

3/13/97

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home,  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Stage IV Alzheimer

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease  
Congestive Heart Failure

Hypertension - remote.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bonita G. Krempel-Porter

29c. License number

H 44057

29d. Date signed (Month, Day, Year)

03-11-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bonita G. Krempel-Porter DO. Emmitsburg, MD 21727

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Julia Davidson-Randall

4  
State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09148

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ellen M. McDonald				2. Date of Death Month Day Year 03/08/97		3. Time of Death 9:45 PM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-28-4546		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) May 19, 1911	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 10311 Gilmore Drive		10f. Zip Code 20901		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Specialist		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Martin McDonald				18. Mother's Name (First, Middle, Maiden Surname) Sarah Gallagher			
	19a. Informant's Name/Relationship (Type, Print) Kevin Joseph McDonald				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12037 Crimson Lane, Silver Spring, MD 20904			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State Washington, DC		20d. Date 3/12/97	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. S. Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. END-STAGE CHRONIC RENAL DISEASE 1-24 YEARS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA - PNEUMONIA				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Lawrence J. Marcus, MD				29c. License number D09215		29d. Date signed (Month/Day, Year) 3/09/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWRENCE J. MARCUS, M.D. - 10313 GEORGIA AVE #207 SILVER SPRING, MD 20902							
	31. Date filed (Month, Day, Year) MAR 12 1997				32. Registrar's Signature Julia Davidson-Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



97 09149

DMMH 16 Rev 6/95





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09150

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice Brigid McKenzie

2. Date of Death

Month Day Year  
March 7, 1997

3. Time of Death

9:30 PM

4a. Facility Name (If not Institution, give street and number)

Sacred Heart Home

4b. City, Town, or Location of Death

Hyattsville, MD

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

081-22-1999

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 23, 1901

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

none

10b. County

none

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1815 H St., N.W. #900

10f. Zip Code

20016

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic work

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

Michael (NMN) McKenzie

18. Mother's Name (First, Middle, Maiden Surname)

Ellen (NMN) Browne

19a. Informant's Name/Relationship (Type, Print)

Philip Collins/lawyer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 65266 Washington, DC 20035-5266

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

Mar. 10, '97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility DeVol Funeral Home

2222 Wisconsin Ave., N.W.  
Washington, D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sudden

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia; left hemiplegia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

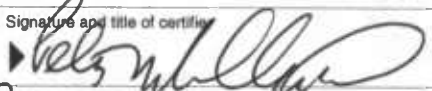
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 22780

29d. Date signed (Month, Day, Year)

3/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

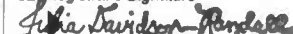
Peter M Schirer MD 7500 Greenway Ctr Dr. Greenbelt Md 20770

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09151

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marchetta H. McGloin				2. Date of Death Month Day Year March 2, 1997		3. Time of Death 9:40 PM						
	4a. Facility Name (If not institution, give street and number) 10512 Westlake Drive, #302				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 311-20-1304	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 5, 1925	9. Birthplace (State or Foreign Country) Indiana						
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Bethesda			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	10e. Street and Number 10512 Westlake Drive, #302			10f. Zip Code 20817		10g. Citizen of What Country? United States							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Federal Government							
	17. Father's Name (First, Middle, Last) Rupert E. Hamilton				18. Mother's Name (First, Middle, Maiden Surname) Ethel Edna James								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Catherine J. Hannon/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4731 Wyaconda Road, Rockville, Maryland 20852								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Location - City or Town, State Bethesda, Maryland		20d. Date March 6, 1997						
	21. Signature of Funeral Service Licenses [Signature] M00803		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Myocardial Infarction</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Coronary Artery Disease</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	Approximate Interval Between Onset and Death	b. Coronary Artery Disease	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	Approximate Interval Between Onset and Death											
	b. Coronary Artery Disease												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred									
		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier [Signature]				29c. License number D06349		29d. Date signed (Month, Day, Year) March 3, 1997							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John E. Kelly, M.D., 2401 Research Blvd., #342, Rockville, Maryland 20850													
31. Date filed (Month, Day, Year) MAR 11 1997				32. Registrar's Signature [Signature]									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 09152

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH BERNARD MUDD</b>				2. Date of Death Month <b>MARCH</b> Day <b>12</b> Year <b>1997</b>		3. Time of Death <b>9:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i>				4b. City, Town, or Location of Death <i>Clinton</i>		4c. County of Death <i>Prince George's</i>	
Funeral Director	5. Social Security Number <b>579-14-0207</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPTEMBER 1, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>BRANDYWINE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6510 MARBURY ROAD</b>		10f. Zip Code <b>20613</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATOR CLERK</b>		16b. Kind of Business/Industry <b>DEPARTMENT OF THE NAVY</b>				
17. Father's Name (First, Middle, Last) <b>WILLIAM ELZARE MUDD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CONSTANCE MUDD</b>				
19a. Informant's Name/Relationship (Type, Print) <b>CHARLES EDWARD MUDD/NEPHEW</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6508 MARBURY ROAD, BRANDYWINE, MARYLAND 20613</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>RESURRECTION CEMETERY</b>		20c. Date <b>3/15/1997</b>		20d. Location - City or Town, State <b>CLINTON, MARYLAND</b>		
21. Signature of Funeral Service Licensee <i>Mark G. Brohawn</i> <b>JPB MARK G. BROHAWN MO0053</b>		22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC.</b> <b>P.O. BOX 156, WALDORF, MARYLAND 20604</b>						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <i>Aspiration Pneumonia</i> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <i>5 days</i>				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <i>fever sepsis</i> Due to (or as a consequence of):		<i>5 days</i>				
		c. <i>Acute Cholecystitis &amp; Gallstone</i> Due to (or as a consequence of):		<i>6 months</i>				
		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. Bernard M. D. Attending</i>		29c. License number <b>D-24535</b>		29d. Date signed (Month, Day, Year) <b>3/13/97</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LAXMI N. BERWA, 7700 OLD BRANCH AVE., SUITE C-101, CLINTON, MARYLAND 20735</b>								
31. Date filed (Month, Day, Year) <b>MAR 17 1997</b>		32. Registrar's Signature <i>John A. Russell</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09153

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward A. Maguire, Sr.

2. Date of Death

Month

Day

Year

3. Time of Death

March

7

1997

9 PM

4a. Facility Name (If not institution, give street and number)

1015 Ross Thumb Rd.

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

166-05-6395

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Dorchester

Cambridge

1 ☐ Yes 2 ☒ No

10e. Street and Number

1015 Ross Thumb Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

President

16b. Kind of Business/Industry

Mechanical Contractor

17. Father's Name (First, Middle, Last)

Joseph F. Maguire

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth A. Murray

19a. Informant's Name/Relationship (Type, Print)

Edward A. Maguire - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 Pine Hill Rd., Ashland, Mass., 01721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Westminster Cemetery 3-15-97 Philadelphia, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.

308 High St., Cambridge, MD 21613

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Cardiac death

seconds

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

9 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Edmund J. MacLaughlin, 10 Aurora St., Cambridge, MD 21613

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 14 1997

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09154

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Louise Marshall

2. Date of Death

Month

Day

Year

March 8, 1997

3. Time of Death

9:50 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

157-20-8867

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 20 1920

9. Birthplace (State or Foreign Country)

Bronx NY

Usual Residence of Decedent

10e. State

MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

113 First Avenue

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Social Worker, Educator

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Hugh Marshall

18. Mother's Name (First, Middle, Maiden Surname)

Anna Zincke

19a. Informant's Name/Relationship (Type, Print)

Rev. Lawrence J. Gesy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 First Avenue, Brunswick, MD 21716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Mary's Cemetery

Date

3/12

20c. Location - City or Town, State

Petersville MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home

100 Petersville Rd Brunswick MD 21716

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic vessel disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. P. Henry, MD

29c. License number

D35553

29d. Date signed (Month, Day, Year)

3/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. P. Henry 610 9th Ave. Brunswick, MD 21769

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

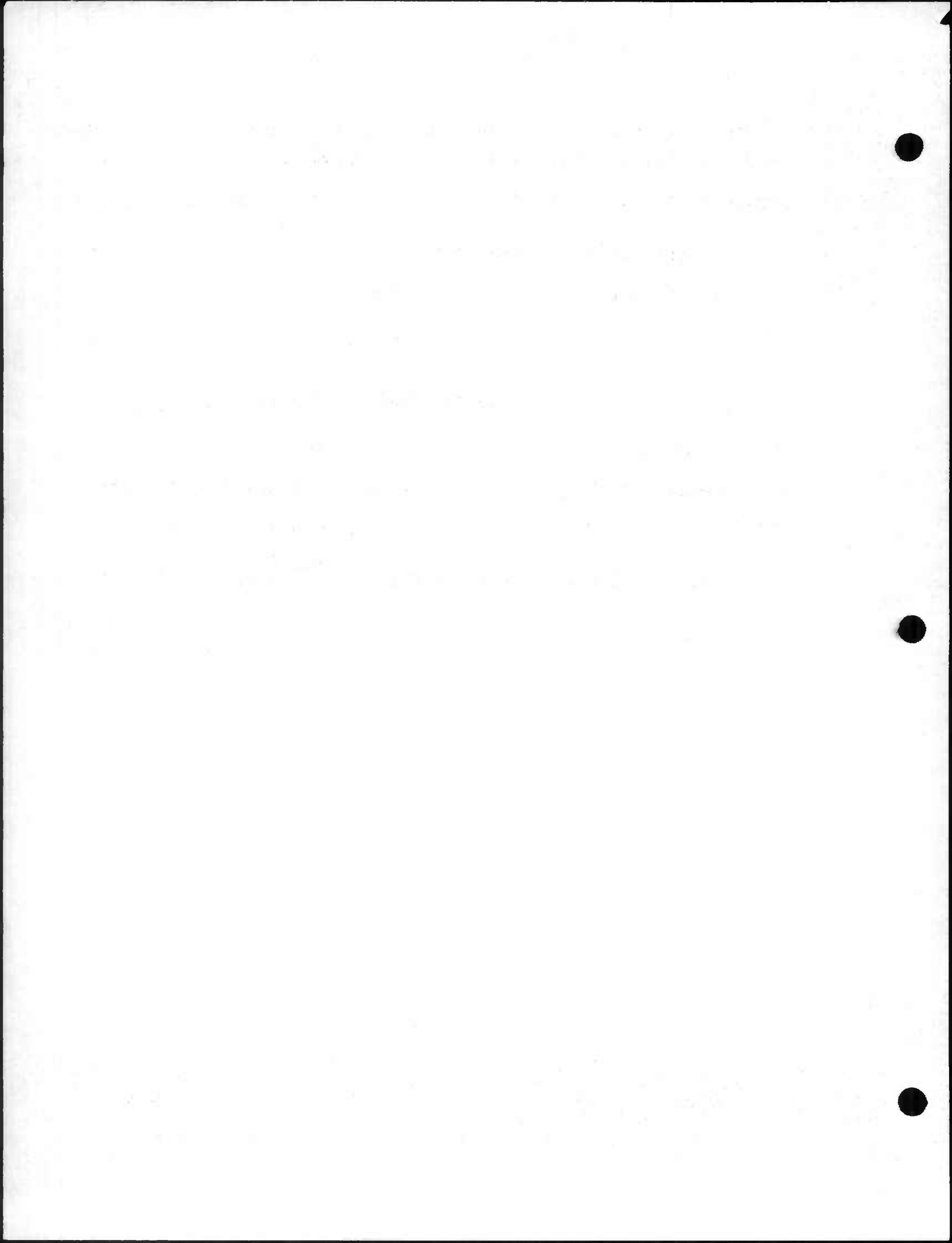
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09155

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN MONROE NAVE					2. Date of Death Month Day Year MARCH 5 1997		3. Time of Death 21:20							
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL					4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY							
Funeral Director	5. Social Security Number 217-10-1435		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 20 1910		9. Birthplace (State or Foreign Country) PA.						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State PA.		10b. County BEDFORD		10c. City, Town or Location BEDFORD			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number RFD#3 BOX#420 LAKE GORDON ROAD				10f. Zip Code 15522		10g. Citizen of What Country? U.S.A.								
	11. Marital Status 1 <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) QUEEN CITY BREWERY			16b. Kind of Business/Industry BREWERY							
	17. Father's Name (First, Middle, Last) HOSEA S. NAVE					18. Mother's Name (First, Middle, Maiden Surname) MINERVA E. BOOR									
	19a. Informant's Name/Relationship (Type, Print) OLA MAE NAVE WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#3 BOX#420 BEDFORD, PA. 15522										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY MARCH 8 1997		20c. Location - City or Town, State CUMBERLAND MARYLAND								
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition resulting in death) a. <i>COR PULMONALE</i> Due to (or as a consequence of): b. <i>Congenital Heart Failure</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Unknown Unknown				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Colonic mass/structure</i> <i>PNEUMONIA CHRONIC OBSTRUCTIVE lung disease</i> <i>Depression Failure to thrive</i>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <i>Robert Welik</i>		29c. License number D31875		29d. Date signed (Month, Day, Year) MARCH 6/97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WELIK, ROBERT, M.D. 902 SETON DRIVE CUMBERLAND, MD. 21502															
31. Date filed (Month, Day, Year) MAR 07 1997										32. Registrar's Signature <i>John Davidson Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09156

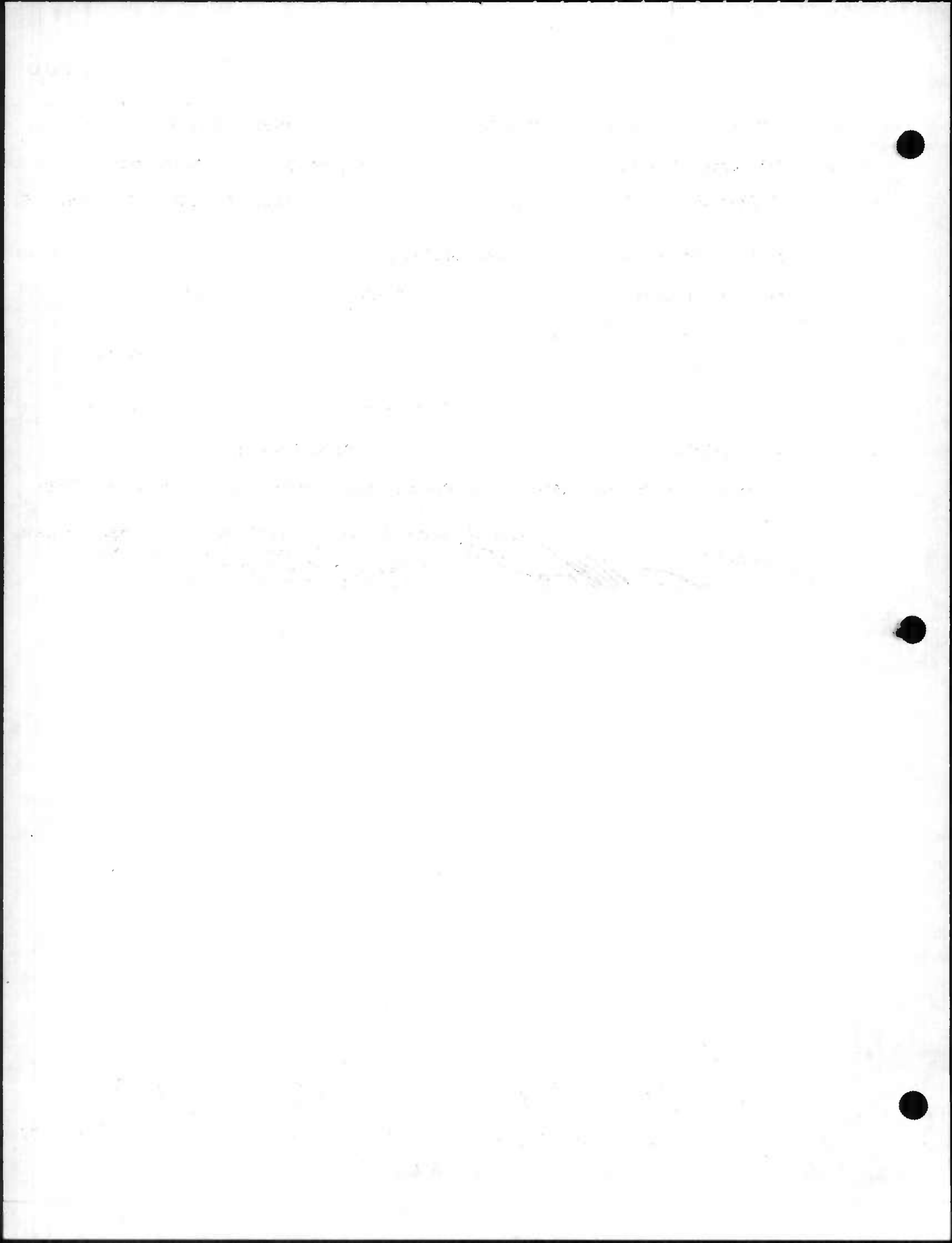
## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George John Nichols				2. Date of Death Month Day Year March 8, 1997		3. Time of Death 10:05 PM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-52-2820		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 15, 1938	
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1102 Carson Street		10f. Zip Code 20901		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) John Nichols		18. Mother's Name (First, Middle, Maiden Surname) Celia Tougas					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Frances Glenn Garner / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Carson Street, Silver Spring, Maryland 20901			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Maryland		20d. Date 3/12/97	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Bulent Zaim		29c. License number D050969		29d. Date signed (Month, Day, Year) 3/9/97	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BULENT ZAIM MD, 11119 ROCKVILLE PIKE MD				31. Date filed (Month, Day, Year) MAR 12 1997			
	32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

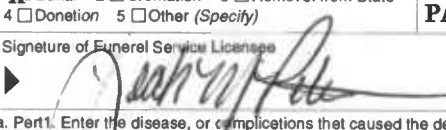

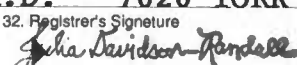
State of Maryland / Department of Health and Mental Hygiene

97 09157

Amended #7, 3/13/97, GF, Mont.Co.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GRADIE TURNER NORDBERG</b>			2. Date of Death Month <b>MARCH</b> Day <b>9</b> Year <b>1997</b>		3. Time of Death <b>5:40 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SAINT JOSEPH MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>TOWSON, MD.</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>579.54.5414</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> <del>84</del> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 13, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>TENNESSEE</b>		10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>BETHESDA</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>6316 WISCASSET ROAD</b>		10f. Zip Code <b>20816</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>+1</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATIVE ASSISTANT</b>		16b. Kind of Business/Industry <b>N.I.H.</b>	
	17. Father's Name (First, Middle, Last) <b>DAVID ROBERT LEE TURNER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MATTIE E. PARISH</b>		19a. Informant's Name/Relationship (Type, Print) <b>JIM NORDBERG/SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14413 QUIETWOOD TERRACE GAITHERSBURG, MD. 20878</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKLAWN MEM. PARK</b>		20c. Location - City or Town, State <b>3/12/97 ROCKVILLE, MD.</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>JOSEPH GAWLER'S SONS, INC. 5130 WI AVE NW WASHINGTON DC 20016</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>f. ANOXIC ENCEPHALOPATHY</b>		Approximate Interval Between Onset and Death <b>ONE DAY</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier 		29c. License number <b>D30263</b>		29d. Date signed (Month, Day, Year) <b>3-9-97</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>FRANCIS KHOO, M.D. 7620 YORK RD. TOWSON, MD. 21204</b>	
31. Date filed (Month, Day, Year) <b>MAR 13 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

State  
Registrar

1. The first part of the document is a list of names and addresses of the members of the committee.

2. The second part of the document is a list of the names and addresses of the members of the committee.

3. The third part of the document is a list of the names and addresses of the members of the committee.

4. The fourth part of the document is a list of the names and addresses of the members of the committee.

5. The fifth part of the document is a list of the names and addresses of the members of the committee.

6. The sixth part of the document is a list of the names and addresses of the members of the committee.

*[Handwritten signature]*

7. The seventh part of the document is a list of the names and addresses of the members of the committee.

8. The eighth part of the document is a list of the names and addresses of the members of the committee.

9. The ninth part of the document is a list of the names and addresses of the members of the committee.

10. The tenth part of the document is a list of the names and addresses of the members of the committee.

11. The eleventh part of the document is a list of the names and addresses of the members of the committee.

12. The twelfth part of the document is a list of the names and addresses of the members of the committee.

13. The thirteenth part of the document is a list of the names and addresses of the members of the committee.

14. The fourteenth part of the document is a list of the names and addresses of the members of the committee.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09158

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Everett Oliver

2. Date of Death

MAR 7 97

Day Year

3. Time of Death

510 A.M.

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

223-18-5942

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

December 27, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4217 Ambler Drive

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Commissary Clerk

16b. Kind of Business/Industry

Department of Army

17. Father's Name (First, Middle, Last)

Reuben H. Oliver

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Moon

19a. Informant's Name/Relationship (Type, Print)

Erma L. Oliver/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4217 Ambler Drive Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)March 10, 1997  
River View Cemetery

Date

20c. Location - City or Town, State

Charlottesville, Virginia

21. Signature of Funeral Service Licensee

G. J. Hepler

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

24 HRS

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. ANOXIC BRAIN DAMAGE

Due to (or as a consequence of):

1 MO

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY, PAROXYSMAL

ARRHYTHMIAS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Rosenthal MD

29c. License number

D04766

29d. Date signed (Month, Day, Year)

3-7-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DANIEL ROSENBLUM 10400 CONNECTICUT AV 606 KENSINGTON, MD 20895

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09159

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUSSELL J. Powell		2. Date of Death Month Day Year March 14 1997		3. Time of Death 0615
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 217-36-0147	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 08/18/1906		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County SOMERSET	10c. City, Town or Location PRINCESS ANNE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 12551 PALMETTO CHURCH ROAD		10f. Zip Code 21853		10g. Citizen of What Country? U.S.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FARMER		16b. Kind of Business/Industry AGRICULTURE		
	17. Father's Name (First, Middle, Last) ELIJAH POWELL		18. Mother's Name (First, Middle, Maiden Surname) ANN ADAMS		
	19a. Informant's Name/Relationship (Type, Print) ROBERT POWELL/SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12551 PALMETTO CHURCH ROAD, PRINCESS ANNE, MD. 21853		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BEECHWOOD CEMETERY		20c. Location - City or Town, State 03/16/97 PRINCESS ANNE, MD.
	21. Signature of Funeral Service Licensee <i>James L. Hiram</i> MO0295		22. Name and Address of Facility (Give kind of work done during most of working life. DO NOT use retired) HINMAN FUNERAL HOME 11673 SOMERSET AVENUE, PRINCESS ANNE, MD. 21853		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure				
	Due to (or as a consequence of): ASCVD				
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aneurysm Rheumatoid arthritis chronic renal failure				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <i>C. Hegman</i> MS		29c. License number D25219		29d. Date signed (Month, Day, Year) 3-14-97
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES STEBBINS, M.D. 30434 MT VERNON RD PRINCESS ANNE, MD				
	31. Date filed (Month, Day, Year) MAR 14 1997		32. Registrar's Signature <i>Julia Davis</i>		

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09160

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard C. Perry</b>				2. Date of Death Month <b>March</b> Day <b>12</b> Year <b>1997</b>		3. Time of Death <b>4:04 a.m.</b>			
	4a. Facility Name (If not institution, give street and number) <b>Dorchester General Hospital</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>			
Funeral Director	5. Social Security Number <b>220-26-1161</b>		6. Sex <b>10 M 20 F</b>	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 10, 1929</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>		10d. Inside City Limits <b>1 Yes 2 No</b>			
	10e. Street and Number <b>505 Saunders Avenue</b>				10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.</b>			
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>1951-1953</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>		16b. Kind of Business/Industry <b>Board of Education</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Frank Roberts</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lushia Perry</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Lillian N. Perry</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>505 Saunders Avenue Cambridge, Maryland 21613</b>					
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Veteran's Cemetery</b>		20c. Location - City or Town, State <b>Hurlock, Maryland</b>		20d. Date			
	21. Signature of Funeral Service Licensee <b>Janelle C. Henry</b>		22. Name and Address of Facility <b>Henry Funeral Home 510 Washington St. Cambridge, Maryland 21613</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">           Immediate Cause (Final disease or condition resulting in death)            e. <b>Cardiac Arrhythmia</b>            Due to (or as a consequence of):            b. <b>Congestive Heart Failure</b>            Due to (or as a consequence of):            c. <b>Generalized Vascular Disease</b>            Due to (or as a consequence of):            d. <b>Coronary Heart Disease</b> </div> <div style="width: 15%;">           Approximate Interval Between Onset and Death  <b>4 min</b>  <b>4 years</b>  <b>4 years</b>  <b>4 years</b> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hx of CVA</b>									
	23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>									
	24a. Was an autopsy performed? <b>1 Yes 2 No</b>									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>									
	26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b>									
	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred	
	28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>									
	29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D26388</b>		29d. Date signed (Month, Day, Year) <b>03-12-1997</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael Fadden MD 302 Collins, Hurlock Md 21643</b>									
	31. Date filed (Month, Day, Year) <b>MAR 13 1997</b>				32. Registrar's Signature <b>[Signature]</b>					



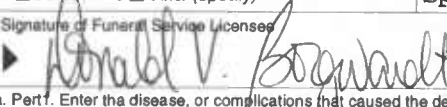
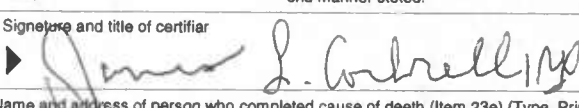

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State of Maryland / Department of Health and Mental Hygiene

97 09161

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rachel Dorothy Pompieri</b>				2. Date of Death Month <b>March</b> Day <b>7</b> Year <b>1997</b>				3. Time of Death <b>20:21</b>					
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>				4c. County of Death <b>Montgomery</b>					
Funeral Director	5. Social Security Number <b>578-42-0196</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Mar. 11, 1932</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>College Park</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number <b>4715 Edgewood Road</b>				10f. Zip Code <b>20740</b>				10g. Citizen of What Country? <b>United States</b>						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>						
17. Father's Name (First, Middle, Last) <b>Charles W. Frazier</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lona B. Baker</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Joan Skipper (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sperryville Cemetery</b>				Date <b>3/13/1997</b>		20c. Location - City or Town, State <b>Sperryville, Virginia</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Congestive Heart Failure</b> Due to (or as a consequence of):  b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 				29c. License number <b>44571</b>				29d. Date signed (Month, Day, Year) <b>March 7, 1997</b>						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>James Cockrell, M.D. 7600 Carroll Avenue Takoma Park, Maryland 20912</b>														
31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09162

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERNE E. POWERS

2. Date of Death

Month

Day

Year

MARCH

10

97

3. Time of Death

19125P

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

524-07-4950

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 2, 1914

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4304 Knowles Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Textbook Editor

16b. Kind of Business/Industry

Book Publishing

17. Father's Name (First, Middle, Last)

Roy Eiler Powers

18. Mother's Name (First, Middle, Maiden Surname)

Eathel Irene Doughty

19a. Informant's Name/Relationship (Type, Print)

Dorothy C. Powers / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4304 Knowles Avenue, Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Elmwood Cemetery

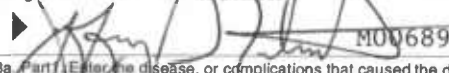
Date

March 14, 1997

20c. Location - City or Town, State

Brighton, Colorado

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SUBDURAL HEMATOMA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 WEEKS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

FEB 7 97

28b. Time of  
Injury

P M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

FELL AT HOME

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

#10

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D07099

29d. Date signed (Month, Day, Year)

MARCH 11 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCES C MAYLE 1025 FERNWOOD RD BETHESDA MD 20817

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

97 09163

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Don A. Premo

2. Date of Death

March 11, 1997

3. Time of Death

8:23 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

229-22-3334

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 7, 1927

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5815 Greenlawn Drive

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1945-195413. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

Bernard Premo

18. Mother's Name (First, Middle, Maiden Surname)

Grace Squires

19e. Informant's Name/Relationship (Type, Print)

Anne R. Premo/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5815 Greenlawn Drive, Bethesda, Maryland 20814

20a. Method of Disposition

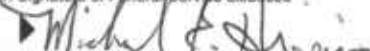
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)March 13, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee



M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

9 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D30484

29d. Date signed (Month, Day, Year)

March 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Umosella, M.D. 5454 Wisconsin Avenue, #1625, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 + 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09164

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LISTON H. Pennington, Sr.

2. Date of Death

March 13, 1997

Day

Year

3. Time of Death

1055

4a. Facility Name (If not institution, give street and number)

Deaton Specialty Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

235-26-6131

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 16, 1921

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

4713 Branchville Road

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

XX Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Master Plummer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Willard L.H. Pennington

18. Mother's Name (First, Middle, Maiden Surname)

Otha Retta Wilson

19a. Informant's Name/Relationship (Type, Print)

Liston H. Pennington, III (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

368 Old Line Avenue Laurel, Maryland 20724

20a. Method of Disposition

XX Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Primitive Baptist Church Cemetery

Date

3/16/1997 Burtonsville, Md.

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Road Beltsville, Md. 20705

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Urinary tract infection

Days

b. Due to (or as a consequence of):

GI bleed

days

c. Due to (or as a consequence of):

Hypertension

Yrs

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SCIB was Ds order

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pritham S. Saini

29c. License number

D28998

29d. Date signed (Month, Day, Year)

March 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRITHAM S SAINI MD

9101 CHERRY LN #211  
Laurel MD 20708

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09165

Amended #19a, 3/17/97, GF, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elfreda Powell				2. Date of Death Month: 03 Day: 08 Year: 97				3. Time of Death 12:44 A.M.	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 216-64-5035		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 17, 1912		9. Birthplace (State or Foreign Country) Jamaica	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10a. Street and Number 803 S. Belgrade Road				10f. Zip Code 20902		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Assistant				16b. Kind of Business/Industry Private			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Samuel Howard				18. Mother's Name (First, Middle, Maiden Surname) Julia Bailey					
	19a. Informant's Name/Relationship (Type, Print) B. Jean <del>Curling</del> (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 S. Belgrade Road, Silver Spring, MD 20902					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD		20d. Date 3/15/97			
	21. Signature of Funeral Service Licensee Thomas S. Clyburn				22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W., Washington, D.C. 20012					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GRAM - NEGATIVE SEPTICEMIA Due to (or as a consequence of): b. URINARY TRACT INFECTION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death HOURS HOURS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANOXIC ENLEPHALOPATHY ASPIRATION PNEUMONIA									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier		29c. License number D36046		29d. Date signed (Month, Day, Year) 3/8/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN J. MERENDINO JR, M.D. 4701 RANDOLPH RD # 216 ROCKVILLE, MD 20852										
31. Date filed (Month, Day, Year) MAR 12 1997				32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09166

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Jack Dean Philpot, Sr.</b>				2. Date of Death Month <b>March</b> Day <b>9</b> Year <b>1997</b>		3. Time of Death <b>0005 an</b>	
4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace Harford</b>		4c. County of Death <b>Harford</b>	
5. Social Security Number <b>220-20-2546</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 7, 1927</b>	
9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>819 Randolph Drive</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-47</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor-planner</b>		16b. Kind of Business/Industry <b>Bethlehem Steel</b>		17. Father's Name (First, Middle, Last) <b>Lawrence Philpott</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Suddoth</b>		19a. Informant's Name/Relationship (Type, Print) <b>Karen L. Philpot</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>819 Randolph Dr., Aberdeen, Maryland 21001</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dublin Southern Cemetery</b>		20c. Location - City or Town, State <b>3/12/97 Darlington, MD</b>		21. Signature of Funeral Service Licensee <b>Mary R. Rothmann</b>		22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Subarachnoid Bleed</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>hour</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Primary Thrombocythemia</b>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier <b>René P. de los Santos</b>		29c. License number <b>D14036</b>		29d. Date signed (Month, Day, Year) <b>March 9, 1997</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2835 Clunehill Rd - Clunehill, Md - 21028</b>	
31. Data filed (Month, Day, Year) <b>MAR 11 1997</b>		32. Registrar's Signature <b>John Paulsen</b>		33. Registrar's Title <b>Registrar</b>		34. Registrar's Office <b>State Registrar</b>	



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09167

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) NORMAN HUGH Penny packer, SR.				2. Date of Death Month Day Year 03 16 97		3. Time of Death 2350	
4a. Facility Name (If not institution, give street and number) Dorchester General, 300 Byrn St. Cambridge				4b. City, Town, or Location of Death Dorchester		4c. County of Death Dorchester	
5. Social Security Number 213-12-2007		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 19, 1915	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent							
10a. State MARYLAND		10b. County DORCHESTER		10c. City, Town or Location HURLOCK		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6486 SUICIDE BRIDGE ROAD				10f. Zip Code 21643		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1944		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER/OPERATOR		16b. Kind of Business/Industry RESTAURANT/TAVERN	
17. Father's Name (First, Middle, Last) HARMON PENNYPACKER				18. Mother's Name (First, Middle, Maiden Surname) LILLIAN KILMON			
19a. Informant's Name/Relationship (Type, Print) MARGARET ANN PENNYPACKER/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. BOX 117, EAST NEW MARKET, MD 21631			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY		Date 3/17/97		20c. Location - City or Town, State CAMBRIDGE, MARYLAND	
21. Signature of Funeral Service Licensee <i>Samuel D. Zeller</i>				22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Pneumonia</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>S/P Cerebrovascular Accident</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Samuel D. Zeller MD</i>		29c. License number D-28209		29d. Date signed (Month, Day, Year) March 17, 1997	
30. Name and address of person who completed Cause of death (Item 23a) (Type, Print) Edmund J MacLaughlin 4 Aurora St. Cambridge, Md 21613							
31. Date filed (Month, Day, Year) MAR 18 1997		32. Registrar's Signature <i>Johanna Anderson-Randall</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09168

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE

AGNES

PEDDICORD

2. Date of Death

Month Day Year  
MARCH 8, 1997

3. Time of Death

8:10 PM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

214-12-9028

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 6, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Monkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16613 J.M. Pearce Road

10f. Zip Code

21111

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher - High School

16b. Kind of Business/Industry

Private School

17. Father's Name (First, Middle, Last)

John Edward O'Neill

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Agnes Thuman

19a. Informant's Name/Relationship (Type, Print)

R. Christopher Peddicord-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16613 J.M. Pearce Rd., Monkton, MD 21111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Grdns.

Date

3-12-97

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

*Stephen A. Hughes*

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

50 W. Broadway, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ACUTE PULMONARY EDEMA

Approximate Interval Between Onset and Death

2 DAYS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Joginder P. Mehta M.D.*

29c. License number

D41410

29d. Date signed (Month, Day, Year)

March 09, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

*Johanna R. Randall*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

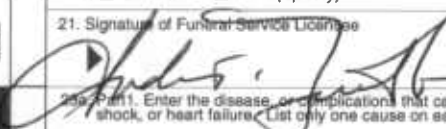
97 09169

Amended #7, 3/14/97, JW, Montg. Cty.

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>HOMER ASBURY RANSOM</b>				2. Date of Death Month Day Year <b>March 12, 1997</b>		3. Time of Death <b>11:30 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Springbrooke Adventist Nursing Home</b>				4b. City, Town, or Location of Death <b>Silver Spring,</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>289-14-1458</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> <del>79</del> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 7, 1918</b>	
9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring,</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>13232 Glenhill Road</b>				10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>Homer Asbury Ransom, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Joyce R. Latham</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Barbara DePriest - Daughter-in-law</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13232 Glenhill Road, Silver Spring, Maryland 20904</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Dale Cemetery</b>		20c. Date <b>3-17-97</b>		20d. Location - City or Town, State <b>Urbana, Ohio</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904</b>			
23a. Part I. Enter the disease, or a combination, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HYPOXIA</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c. SIGMOID VOLVULUS</b> Due to (or as a consequence of): <b>d. PARKINSON DISEASE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death <b>3 Days</b> <b>3 Days</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Dr. Homelland, PHYSICIAN</b>				29c. License number <b>D40804 M.D.</b>		29d. Date signed (Month, Day, Year) <b>March 12, 1997</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Kewal K. Sharma, M.D., 10620 Georgia Avenue, Suite 114, Silver Spring, MD 20902</b>							
31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>				32. Registrar's Signature <b>Julia Davidson-Rendell</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09170

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mary V. Rothenhoefer

2. Date of Death

March 7, 1997

3. Time of Death

8:13 A.M.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

381-18-5300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 21, 1924

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2409 Bear Den Road

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Howard Van Auken

18. Mother's Name (First, Middle, Maiden Surname)

Mable Hanlon

19a. Informant's Name/Relationship (Type, Print)

David A. Rothenhoefer/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2409 Bear Den Road, Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

March 11, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue  
Rockville, Maryland 20850-280523a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Lung Cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Middle Cerebral Artery Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Mary P. Howell M.D.

29c. License number

D46075

29d. Date signed (Month, Day, Year)

3/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Howell, M.D., 915 Tollhouse Road, #203, Frederick, MD 21701

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09171

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Cornelia B. Rhodes

2. Date of Death

March 6, 1997

3. Time of Death

1:11 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

242-52-0896

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 4, 1914

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5101 Ridgefield Road

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

18b. Kind of Business/Industry

College

17. Father's Name (First, Middle, Last)

Henry Biediger

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Iltis

19a. Informant's Name/Relationship (Type, Print)

Kathryn W. Birch / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8008 River Falls Drive, Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

March 7, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michelle P. Kutta

M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Edema

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas S. Goldbaum, M.D.

29c. License number

D30885

29d. Date signed (Month, Day, Year)

March 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas S. Goldbaum, M.D., 5530 Wisconsin Ave., #515, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



97 09172

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HOWARD CURTIS ROHER</b>				2. DATE OF DEATH MONTH <b>3</b> DAY <b>6</b> YEAR <b>97</b>		3. TIME OF DEATH <b>3:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>064-05-8458</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6 05 12</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MUNNSVILLE, NY</b>				9a. FACILITY NAME (If not institution, give street and number) <b>17117 LONGDRAFT ROAD</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>GAITHERSBURG</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>MONTGOMERY</b>				10c. CITY, TOWN OR LOCATION <b>GAITHERSBURG</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>17117 LONGDRAFT ROAD</b>			
10f. ZIP CODE <b>20878</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ADMINISTRATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>EARL WALLACE ROHER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ANN SOPHRONA LANDERS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RICHARD T ROHER (SON)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12016 WINESAP TERR. NORTH POTOMAS, MD 20878</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, other place) <b>EAST RIDGE LAWN CEM. 3/10/97</b>		20c. LOCATION — City or Town, State <b>DELAWARE N.J.</b>		20d. DATE <b>3/10/97</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James C. Dooly</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis J. Collins Funeral Home, Inc. 20901 500 University Blvd. W., Silver Spring, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PARKINSONISM</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>atrial fibrillation</b> <b>stroke with seizure disorder</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George F. Sengstack MD</i>				29c. LICENSE NUMBER <b>D12121</b>		29d. DATE SIGNED (Month, Day, Year) <b>3-6-97</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GEORGE F SENGSTACK, MD 3929 FERRARA DR WHEATON MD 20906</b>							
31. DATE FILED (Month, Day, Year) <b>MAR 10 1997</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09173

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STEVEN ERIC ROGERS</b>						2. Date of Death Month Day Year <b>MARCH 8, 1997</b>		3. Time of Death <b>0300AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>MONTGOMERY GENERAL HOSPITAL E.R.</b>						4b. City, Town, or Location of Death <b>OLNEY</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>463-41-8896</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>26</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 2, 1971</b>		9. Birthplace (State or Foreign Country) <b>TEXAS</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GERMANTOWN</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>18727 GINGER CT.</b>				10f. Zip Code <b>20876</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1990-1997</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>U. S. NAVY</b>			16b. Kind of Business/Industry <b>DEFENSE</b>		
	17. Father's Name (First, Middle, Last) <b>JAMES ROGERS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE PLAGENS</b>					
Physician /Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>MICHELLE ROGERS/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>316 SPRINGFIELD CT., ORANGE PARK, FLA. 32073</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HOUSTON NATIONAL CEMETERY 3/11</b>			20c. Location - City or Town, State <b>HOUSTON, TX.</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>400091</b>				22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year) <b>3-8-97</b>		28b. Time of Injury <b>0257M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred <b>Automobile accident</b>	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>West 1081 Reilly Road Montgomery County, Maryland</b>					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> <b>MP</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>MARCH 9, 1997</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, MP 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>					
32. Registrar's Signature <i>[Signature]</i>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09174

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA M. RESHETAR

2. Date of Death

Month Day Year  
MARCH 13, 1997

3. Time of Death

11:44 pm

4a. Facility Name (If not institution, give street and number)

PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

165-10-7622

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 30 1908

9. Birthplace (State or Foreign Country)

Austria

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

PO Box 488

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Demetro Michalyshin

18. Mother's Name (First, Middle, Maiden Surname)

Catherine (Unknown) Michalyshin

19a. Informant's Name/Relationship (Type, Print)

Mary Ann Hayden (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 488 La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St Mary's Ukrainian Cem

Date

3-19-97

20c. Location - City or Town, State

Schuylkill Co. PA

21. Signature of Funeral Service Licensee

John H. Eberwein M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary

4433 White Pls La White Pls., MD 20695

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Cardiac arrhythmia

Due to (or as a consequence of):

b.

End-stage Cardiomyopathy

Due to (or as a consequence of):

c.

Hypertension

Due to (or as a consequence of):

d.

Cerebrovascular accidents

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerosis, congestive Heart Failure, Anemia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Pritchett

29c. License number

D08370

29d. Date signed (Month, Day, Year)

3/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL PRITCHETT, MD, 188 LA GRANGE AVENUE PO BOX 1317 LAPLATA MD20646

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

John H. Eberwein

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09175

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Joseph Carlyle Roberts

2. Date of Death

Mar 16 1997 Year

3. Time of Death

1:10 AM

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

216-40-6138

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEBRUARY 19, 1912 MARYLAND

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1207 PATUXENT DRIVE

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INSPECTOR/CONTROLLMAN

16b. Kind of Business/Industry

U. S. NAVY

17. Father's Name (First, Middle, Last)

JOHN ZACHARIAH ROBERTS

18. Mother's Name (First, Middle, Maiden Surname)

SARAH MOLLIE LYON

19a. Informant's Name/Relationship (Type, Print)

DOROTHY F. ROBERTS/ SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1207 EAST PATUXENT DRIVE, LA PLATA, MARYLAND 20646

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HUNTT CREMATORY

Date

3/16/1997 WALDORF, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOHN P. KNISLEY

A-00719

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.

P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Aspiration

Due to (or as a consequence of):

b.

Parkinson Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Henry Burke MD

29c. License number

D01009

29d. Date signed (Month, Day, Year)

3-16-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henry Burke, MD 115-A LaGrange Ave P.O. Box 2539 LaPlata Md 20646

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Legible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09176

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Kenneth EARL Rexroth SR.</b>				2. Date of Death Month <b>March</b> Day <b>10</b> Year <b>1997</b>		3. Time of Death <b>9-10 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>				4b. City, Town, or Location of Death <b>Fallston</b>		4c. County of Death <b>Harford</b>	
5. Social Security Number <b>212-01-1928</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 21, 1910</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>303 Lakeside Drive</b>		10f. Zip Code <b>21015</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Fire Marshall</b>		16b. Kind of Business/Industry <b>Sugar Refinery</b>		17. Father's Name (First, Middle, Last) <b>Nelson --- Rexroth</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Fanny Jane Haines</b>		19a. Informant's Name/Relationship (Type, Print) <b>Helen V. Rexroth / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>303 Lakeside Drive, Bel Air, MD 21015</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		20c. Date <b>3/13/97</b>		20d. Location - City or Town, State <b>Bel Air, Maryland</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Respiratory acidosis. Respiratory failure.</b> Due to (or as a consequence of): b. <b>Emphysema, Bronchitis.</b> Due to (or as a consequence of): c. <b>Severe Hypoxaemia.</b> Due to (or as a consequence of): d. <b>Chronic CO2 retention.</b>		Approximate Interval Between Onset and Death <b>1 day</b> <b>30 yrs.</b> <b>5 yrs.</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier 		29c. License number <b>D18424</b>		29d. Date signed (Month, Day, Year) <b>March -10- 1997</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>B.D. PAREKH MD. 1908 HARFORD ROAD FALLSTON MD 21047.</b>	
31. Date filed (Month, Day, Year) <b>MAR 12 1997</b>		32. Registrar's Signature 		33. Registrar's Title <b>Registrar</b>		State Registrar	



Amended #19b, N.H.S.  
3/6/97, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09177

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Ann Smith</b>				2. Date of Death Month <b>MARCH</b> Day <b>5</b> Year <b>1997</b>		3. Time of Death <b>7:34 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>219-34-7212</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 13, 1938</b>	
	10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cresaptown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>14201 Winchester Road SW</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>Louis A. Shepherd, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alta Effie (Ullery)</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Herbey L. Smith-son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14201 Winchester Road SW, Cresaptown MD 21502</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Date <b>03/08</b>		20c. Location - City or Town, State <b>Cumberland, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Scarpelli</b>		22. Name and Address of Facility <b>Scarpelli Funeral Home Cumberland, MD 21502</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cardiac Arrhythmia &amp; cardiac arrest</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { <b>Congestive heart failure</b> <b>Cardiomyopathy</b> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>minutes</b> <b>day</b> <b>month</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Liver disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <b>R. Espina, MD</b>	
To Be Completed by Physician/Medical Examiner	29c. License number <b>DD03459</b>		29d. Date signed (Month, Day, Year) <b>MARCH 6 1997</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. ESPINA, MD 902 SETON DR., CUMBERLAND, MD</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>MAR 06 1997</b>		32. Registrar's Signature <b>John A. Randall</b>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09178

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arrietta Beatrice Shemer			2. Date of Death Month Day Year March 6 1997		3. Time of Death 9:00 AM	
	4e. Facility Name (If not institution, give street and number) 401 Central Ave			4b. City, Town, or Location of Death Westernport		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 215-05-9731		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) Nov 3 1908	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent			10a. State Maryland		10b. County Baltimore	
To Be Completed by Funeral Director	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 714 Anneslie Rd.	
	10f. Zip Code 21212			10g. Citizen of What Country? United States		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home	
	17. Father's Name (First, Middle, Last) George Kidwell			18. Mother's Name (First, Middle, Maiden Surname) Nettie Tasker			
	19. Informant's Name/Relationship (Type, Print) Malverda Metcalf			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Central Ave. Westernport, Md. 21562			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Location - City or Town, State Mar 10, 1997 Baltimore, Md.	
	21. Signature of Funeral Service Licensee Wayne Bal			22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, MD 21562			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			Approximate Interval Between Onset and Death IMMEDIATE			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Hood		29c. License number 16579		
29d. Date signed (Month, Day, Year) 3-7-1997			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhassan Naddad, M.D. 566 S MINERAL ST. KEYSER, WV				
31. Date filed (Month, Day, Year) MAR 10 1997			32. Registrar's Signature John Davidson-Randall				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09179

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leo Albert Smith</b>				2. Date of Death Month <b>March</b> Day <b>9</b> Year <b>1997</b>		3. Time of Death <b>1:15 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Residence - 527 Rose Hill Avenue</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegheny</b>	
Funeral Director	5. Social Security Number <b>214-05-9755</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 12, 1911</b>	
	10a. State <b>Maryland</b>		10b. County <b>Allegheny</b>		10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>527 Rose Hill Avenue</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Postal Worker</b>		16b. Kind of Business/Industry <b>U.S. Post Office</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Hall</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Bertrom Johnson / Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>527 Rose Hill Ave, Cumberland, Md. 21502</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Peter &amp; Paul Cemetery</b>		Date <b>March 11, 1997</b>		20c. Location - City or Town, State <b>Cumberland, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Ernest A. Riley, Jr.</b>				22. Name and Address of Facility <b>Leasure-Stein, Inc., 230 Baltimore Avenue Cumberland, Md. 21502</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Colon Cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Approximate Interval Between Onset and Death <b>5-Years</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>R. D. Chisholm, M.D.</b>				29c. License number <b>D 34362</b>		29d. Date signed (Month, Day, Year) <b>March 10, 1997</b>		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>Roy D. Chisholm, M.D. 924 Seton Dr. Cumberland, Md. 21502</b>								
31. Date filed (Month, Day, Year) <b>MAR 13 1997</b>				32. Registrar's Signature <b>John Davidson-Hardall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09180

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Mary Smith			2. Date of Death Month Day Year MARCH 9 1997			3. Time of Death 1915				
	4e. Facility Name (If not institution, give street and number) Sacred Heart Hospital			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany				
Funeral Director	5. Social Security Number 220-10-8902		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 16, 1913		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland			10b. County Allegany			10c. City, Town or Location Midland			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number Church Hill			10f. Zip Code 21542			10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home				
	17. Father's Name (First, Middle, Last) Frank Leake			18. Mother's Name (First, Middle, Maiden Surname) Lena Higgins							
	19e. Informant's Name/Relationship (Type, Print) Elizabeth Metz-Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16916 Montel Rd S.W., Frostburg, Md. 21532							
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) March 12, 1997 St. Josephs Cemetery			20c. Location - City or Town, State Midland, Md.				
	21. Signature of Funeral Service Licensee James E. Miller			22. Name and Address of Facility Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539							
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure b. pneumonia c. Coronary artery disease d. Cerebral infarct Approximate Interval Between Onset and Death 12 days 14 days 10 yrs 10 yrs										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASVD										
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
To Be Completed by Physician/Medical Examiner	24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Shin Kim M.D. 90 Main Street Westernport, MD 21502			29c. License number D15463			29d. Date signed (Month, Day, Year) MARCH 10, 1997	
State Registrar	31. Date filed (Month, Day, Year) MAR 13 1997			32. Registrar's Signature John Anderson-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



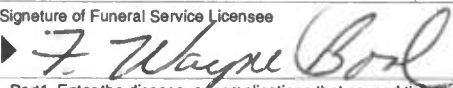

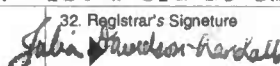
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09181

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Charles Shaw Sr.</b>				2. Date of Death Month <b>March</b> Day <b>15</b> Year <b>1997</b>		3. Time of Death <b>1:02 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>86 Main St.</b>				4b. City, Town, or Location of Death <b>Westernport</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>214-07-3955</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>6/1/1918</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Westernport</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>86 Main St.</b>				10f. Zip Code <b>21562</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INSURANCE AGENT</b>		16b. Kind of Business/Industry <b>INSURANCE</b>		
17. Father's Name (First, Middle, Last) <b>EDWARD SHAW</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELIZABETH PALMER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>KATHERINE SHAW / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>86 MAIN ST. WESTERNPORT, MD. 21562</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LAUREL HILL CEMETERY 3-18-97</b>		20c. Location - City or Town, State <b>BARTON, MD.</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Boal Funeral Home 111 Church St. Westernport, Md. 21562</b>				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Arteriosclerotic heart disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>wk yrs</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D 09157</b>		29d. Date signed (Month, Day, Year) <b>March 15 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Snow, M.D. 124 w 3rd st Cumberland MD 21502</b>								
31. Date filed (Month, Day, Year) <b>MAR 17 1997</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09182

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Thelma Pauline Swadley</u>				2. Date of Death Month <u>March</u> Day <u>19</u> Year <u>1997</u>		3. Time of Death <u>8:44 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Washington County Hospital</u>				4b. City, Town, or Location of Death <u>Hagerstown</u>		4c. County of Death <u>Washington</u>	
Funeral Director	5. Social Security Number <u>225-09-9128</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>78</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 19, 1918</u>	
	9. Birthplace (State or Foreign Country) <u>West Virginia</u>		10a. State <u>Maryland</u>		10b. County <u>Washington</u>		10c. City, Town or Location <u>Hagerstown</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>17607 Woodlawn Drive</u>		10f. Zip Code <u>21740</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Supervisor</u>		16b. Kind of Business/Industry <u>Dry Cleaning</u>			
	17. Father's Name (First, Middle, Last) <u>Jacob Jackson Teets</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Cora Ann Dellinger</u>		19a. Informant's Name/Relationship (Type, Print) <u>John Odell Swadley</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>17607 Woodlawn Drive Hagerstown, MD 21740</u>	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>St. Paul's Church Cemetery 3-22-97 Clear Spring, MD</u>		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Osborne Funeral Home</u> <u>425 S. Conococheague St. Williamsport, MD 21795</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Dissection of Thoracic Aorta</u> Due to (or as a consequence of): <u>Atherosclerosis</u> Due to (or as a consequence of): <u>Hypertension</u> Due to (or as a consequence of): <u></u>		Approximate Interval Between Onset and Death <u>48 hours</u> <u>years</u> <u>years</u>	
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Morbid Obesity</u> <u>Aortic renal failure</u>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u></u>	
	28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred <u></u>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <u></u>	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature] MD</u>		29c. License number <u>D46081</u>		29d. Date signed (Month, Day, Year) <u>March 19, 1997</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Frank J Collins MD 346 Mill St. Hagerstown MD 21740</u>		31. Date filed (Month, Day, Year) <u>MAR 25 1997</u>		32. Registrar's Signature <u>[Signature]</u>				



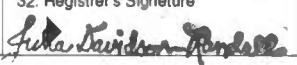
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09183

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leon Hugh Scanlon				2. Date of Death Month Day Year March 10, 1997		3. Time of Death 3:10 P.M.	
	4a. Facility Name (If not institution, give street and number) 11900 Piney Glen Lane				4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 175-28-7707	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 28, 1934	9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Potomac			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 11900 Piney Glen Lane			10f. Zip Code 20854		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 52-56		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) management consultant			16b. Kind of Business/Industry Spencer, Stuart & Asc.		
	17. Father's Name (First, Middle, Last) Leon Scanlon				18. Mother's Name (First, Middle, Maiden Surname) Georgeanna Cochrane			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Melissa Scanlon			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11900 Piney Glen Lane, Potomac, Md. 20854				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Hill Cemetery		Date Mar. 14, 97	20c. Location - City or Town, State Washington, D.C.		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. hepato renal syddrome Due to (or as a consequence of): b. cirrhosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P cerebro vascular accident							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 		29c. License number D 28103	29d. Date signed (Month, Day, Year) March 11, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Harrington, M.D., 3301 New Mexico Ave., N.W., Washington, D.C.								
31. Date filed (Month, Day, Year) MAR 13 1997		32. Registrar's Signature 						



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09184

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY THORNTON SPROUL

2. Date of Death

Month Day Year  
FEB 25 1997

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-14-7798

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
FEBRUARY 3, 1909

9. Birthplace (State or Foreign)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

VA.

10b. County

FAIRFAX

10c. City, Town or Location

MCLEAN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6251 OLD DOMINION DRIVE #449

10f. Zip Code

22101

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFICER MEDICAL CORPS

16b. Kind of Business/Industry

U.S.N.

17. Father's Name (First, Middle, Last)

ROBERT LOWREY SPROUL

18. Mother's Name (First, Middle, Maiden Surname)

RUTH GARDNER

19a. Informant's Name/Relationship (Type, Print)

BOB SPROUL - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3401 WATERTOWN PLACE, BIRMINGHAM, ALABAMA 35243

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL CEMETERY

Date

3/6/97

20c. Location - City or Town, State

ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT J. MURPHY FUNERAL HOME, INC.  
4510 WILSON BLVD. ARLINGTON, VIRGINIA 22203

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MULTI ORGAN SYSTEM FAILURE

e. Due to (or as a consequence of):

SEPSIS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-50274

29d. Date signed (Month, Day, Year)

02-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.J. COSTE, LT, MC, USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09185

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY

SELSKY

2. Date of Death

Month Day Year  
March 7, 1997

3. Time of Death

3:00 am

4a. Facility Name (If not institution, give street and number)

Manor Care Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

570-16-3252

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
7/8/1915

9. Birthplace (State or Foreign Country)

NEBRASKA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5225 POOKS HILL ROAD APT. #422 S.

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

READER

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

NATHAN

18. Mother's Name (First, Middle, Maiden Surname)

BORDY

BESSIE

ABRAHAMSON

19a. Informant's Name/Relationship (Type, Print)

ROBERT SELSKY (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1671 PLEASANT PLAINS ROAD ANNAPOLIS, MARYLAND 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS.

Date

3/10/97

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DEHYDRATION  
Due to (or as a consequence of):

2 wks

c. PNEUMONIA  
Due to (or as a consequence of):

2 months

d. BRONCHIOALVEOLAR CARCINOMA  
Due to (or as a consequence of):

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GLAUCOMA

ENDOCARDITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35996

29d. Date signed (Month, Day, Year)

03-07-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA M BURRELL MD 2101 MEDICAL PARK DRIVE SILVER SPRING, MD 20902

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09186

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James H. Dwiggins, Senior

2. Date of Death

Month Day Year  
March 8 1997

3. Time of Death

0859 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-34-7176

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 28, 1914

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Clarksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23601 Peach Tree Road, Box 132

10f. Zip Code

20871

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Years:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Postal Carrier

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Charles W. Dwiggins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen A. Utz

19a. Informant's Name/Relationship (Type, Print)

James H. Dwiggins, Jr. /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13757 Travilah Road, Rockville, Maryland 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

March 11, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue  
Rockville, Maryland 20850-2805

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation

Due to (or as a consequence of):

b. Dilated Cardiomyopathy

Due to (or as a consequence of):

c. Aortic Stenosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

30 minutes

5 years

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chron. Renal Insufficiency

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Richard Weinstein, MD

29c. License number

D42777

29d. Date signed (Month, Day, Year)

March 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Richard Weinstein 15225 Shady Grove Road #201 Rockville, MD

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

[Signature] John Davidson-Pandell

State  
Registrar

Baltimore, Maryland 21215-0020

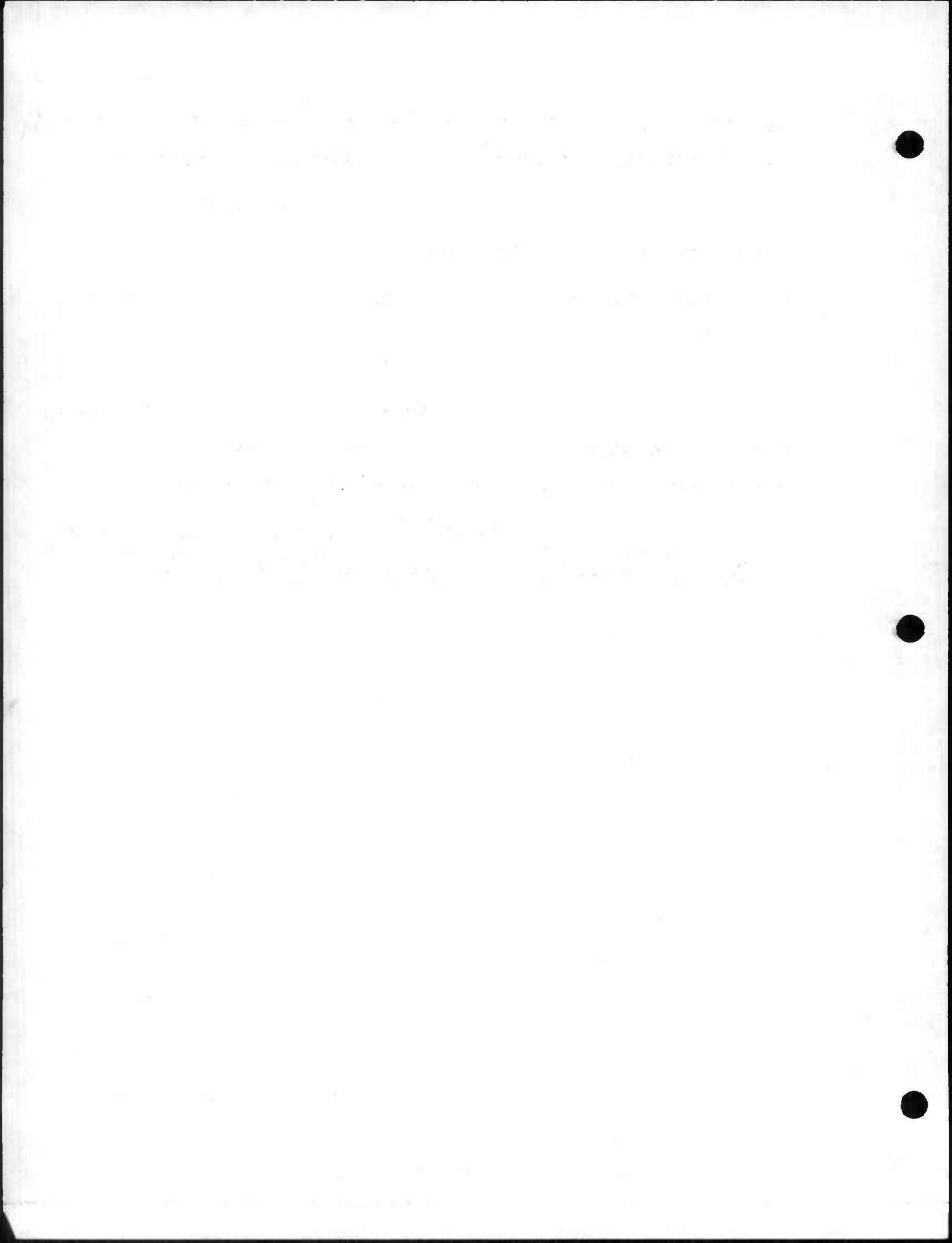
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09187

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Beatrice Catherine Stone</b>				2. Date of Death Month <b>March</b> Day <b>6</b> Year <b>1997</b>		3. Time of Death <b>10:20A.</b>	
	4e. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>049-12-4883</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 26, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Connecticut</b>		10a. State <b>Connecticut</b>		10b. County <b>Hartford</b>		10c. City, Town or Location <b>Windsor Locks</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>259 North Street</b>				10f. Zip Code <b>06096</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>		16b. Kind of Business/Industry <b>Montgomery Co.</b>	
	17. Father's Name (First, Middle, Last) <b>William LaFountain</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Julie Barnaby</b>			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Joan Janczyk (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2823 Vixen Lane Silver Spring, Maryland 20905</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Joseph's</b>		Date <b>3/11/1997</b>		20c. Location - City or Town, State <b>Windsor, Connecticut</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Pneumonia</b> Due to (or as a consequence of):  b. <b>Chronic Obstructive Airway Disease</b> Due to (or as a consequence of):  c. <b>Congestive Heart Failure</b> Due to (or as a consequence of):  d.  Approximate Interval Between Onset and Death <b>3 Days</b> <b>10 Years</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Shameek M.D.</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D40804</b>				29d. Date signed (Month, Day, Year) <b>March 6, 1997</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Kewal K. Sharma, M.D. 10620 Georgia Avenue, #114 Silver Spring, Maryland 20902</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>MAR 11 1997</b>				32. Registrar's Signature <b>Lia Davidson-Randall</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09188

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Duane A. Stromberg

2. Date of Death

March 9, 1997

3. Time of Death

5:35 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

393-26-4742

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 13, 1926

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10000 Brunswick Avenue Apt. 527

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Public Relations Manager

16b. Kind of Business/Industry

Publishing

17. Father's Name (First, Middle, Last)

Arthur Stromberg

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Anderson

19a. Informant's Name/Relationship (Type, Print)

Vern H. Stromberg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4657 West Medford Avenue Milwaukee, Wisconsin 53216

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

3/12/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral-Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Acute Pulmonary Embolism

Due to (or as a consequence of):

36 Hour

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anoxic Encephalopathy

Bladder Cancer (Malignant Neoplasm)

Hypertension

Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35045

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Philip G. Henjum, MD 3416 Olandwood Court, 200 Olney, MD 20832

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD EUGENE STONE				2. Date of Death Month March Day 8, 1997 Year		3. Time of Death 0300a	
	4a. Facility Name (If not Institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 327-66-7315		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 23 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 9, 1973	
	9. Birthplace (State or Foreign Country) Kansas		10. Usual Residence of Decedent		10a. State Kansas		10b. County Geary	
To Be Completed by Funeral Director	10c. City, Town or Location Junction City		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 406 W. 13th., St.		10f. Zip Code 66441	
	10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1991-1997		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -----		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Navy		16b. Kind of Business/Industry Defense	
	17. Father's Name (First, Middle, Last) Richard E. Stone Sr.		18. Mother's Name (First, Middle, Maiden Surname) Janice C. Fox		19a. Informant's Name/Relationship (Type, Print) Richard E. Stone Sr. (Father)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 W. 13th., St. Junction City, Kansas 66441	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highland Cemetery		20c. Date 3/14		20d. Location - City or Town, State Junction City, Kansas	
	21. Signature of Funeral Service Licensee <i>Thomas S. Chambers</i> 679		22. Name and Address of Facility Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, MD. 20737		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. Multiple Injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 3-8-97	
	28b. Time of Injury 0257 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Automobile accident		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Stephen S. Radnitz, MD</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 9, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radnitz, MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) MAR 14 1997		32. Registrar's Signature <i>Julia Davidson-Rendell</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09190

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLAIRE J. SHELLABARGER

2. Date of Death  
Month Day Year

MARCH 12, 1997

3. Time of Death  
11:15 PM

4e. Facility Name (If not institution, give street and number)

15908 MAPLE RIDGE CT.

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

302-16-7279

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT. 23, 1924

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

N.Y.

10b. County

SUFFOLK

10c. City, Town or Location

BELLPORT

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

196 SOUTH COUNTRY RD.

10f. Zip Code

11713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RET.BIOLOGICAL SCIENTIST

16b. Kind of Business/Industry

BIOLOGY

17. Father's Name (First, Middle, Last)

OLIVER NEWTON SHELLABARGER

18. Mother's Name (First, Middle, Maiden Surname)

YVONNE MILLER

19a. Informant's Name/Relationship (Type, Print)

MARILYN SHELLABARGER/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

3/14

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W.W. Chambers M00091

22. Name and Address of Facility

SILVER SPRING, MD.

CHAMBERS FUNERAL HOMES, P.A. 20910

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Aspiration Pneumonia

Due to (or as a consequence of):

b. Dysphagia

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multi-infarct Dementia, Abdominal Aortic

Aneurysm, Peripheral Vascular Disease

Parkinsonian-like disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan J. Miller M.D.

29c. License number

D35579

29d. Date signed (Month, Day, Year)

3/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUSAN J. MILLER, M.D. 5530 WISCONSIN AVE.#915, CHEVY CHASE, MD.

20815

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Sha Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 09191

Amended #7, 3/10/97, JW, Montg. Cty.

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) NELSON SIEVERING  
2. Date of Death Month Day Year MARCH 6, 1997  
3. Time of Death 9:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 4952 SENTINEL DRIVE # 406  
4b. City, Town, or Location of Death BETHESDA, MD  
4c. County of Death MONTGOMERY

5. Social Security Number 197-16-2445  
6. Sex 1 ☐ M 2 ☒ F  
7. Age (In yrs. last birthday) 71 72 Yrs.  
8. Date of Birth (Month, Day, Year) DECEMBER 8 1924  
9. Birthplace (State or Foreign Country) NEWARK, N.J.

Usual Residence of Decedent

10a. State MD  
10b. County MONTGOMERY  
10c. City, Town or Location BETHESDA  
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 4952 SENTINEL DR. #406  
10f. Zip Code 20817  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AMBASSADOR  
16b. Kind of Business/Industry DIPLOMAT

17. Father's Name (First, Middle, Last) NELSON FREDRICK SIEVERING  
18. Mother's Name (First, Middle, Maiden Surname) CLARICE TAYLOR

19a. Informant's Name/Relationship (Type, Print) DOROTHY SIEVERING WIFE  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4952 SENTINEL DRIVE #406, BETHESDA, MD 20817

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) PARKLAWN MEMORIAL PARK  
20c. Location - City or Town, State ROCKVILLE, MD  
20d. Date 3/10/97

21. Signature of Funeral Service Licensee [Signature]  
22. Name and Address of Facility JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVENUE, N.W. WASHINGTON, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. BLADDER CANCER  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
NON-HODGKIN'S LYMPHOMA  
PROSTATE CANCER  
CORONARY ARTERY DISEASE  
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown  
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)  
27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature]  
29c. License number 12851  
29d. Date signed (Month, Day, Year) 3/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES AHLGREN, M.D. 2150 PENNSYLVANIA AVE. NW WASHINGTON DC 20037-2396

31. Date filed (Month, Day, Year) MAR 10 1997  
32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

20

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09192

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Elizabeth Stockman

2. Date of Death

March 10, 1997

3. Time of Death

6:00 p.m.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

219-05-7819

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 31, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

613 Chapel Alley

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Presser

16b. Kind of Business/Industry

Clothing Factory

17. Father's Name (First, Middle, Last)

James Ellsworth

BOYER

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Mae FOGLE

19a. Informant's Name/Relationship (Type, Print)

Mr. James W. Stockman, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7705 Blue Mountain Road, Thurmont, Maryland 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery, March 13, 1997

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard E. Hyl

MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home  
106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CEREBROVASCULAR ACCIDENT

1 Day

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC HEART DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Signature

29c. License number

D43091

29d. Date signed (Month, Day, Year)

3-11-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SABED ZAIDI MD

801 TOLL HOUSE AVE, FREDERICK, MD

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

Signature

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Amended line 1 3/11/97 New Day FCHD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09193

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernedene ETHEL BERENDENE STIMMEL</b>				2. Date of Death Month <b>MAR</b> Day <b>8</b> Year <b>1997</b>		3. Time of Death <b>4:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>8995-A Urbana Church Road</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>214-16-1221</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 6, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8995-A Urbana Church Road</b>				10f. Zip Code <b>21704</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Self</b>		
17. Father's Name (First, Middle, Last) <b>Elmer Harding</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Zennia Soper</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Charles E. Stimmel / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8995-A Urbana Church Road, Frederick, MD 21704</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Data <b>3/12/97</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Robert B. Roberts</b>				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702</b>					
23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): <b>Hypertension, essential</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>MONTHS</b> <b>YEARS</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Robert R. Roberts MD</b>		29c. License number <b>D09867</b>		29d. Date signed (Month, Day, Year) <b>MARCH 8 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RRR ROBERTS MD 75013 MCKAYIG ROAD FREDERICK MD 21701-3319</b>									
31. Date filed (Month, Day, Year) <b>MAR 10 1997</b>				32. Registrar's Signature <b>John A. ...</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09194

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martha Marie Schroyer

2. Date of Death  
Month Day Year

March 6 1997

3. Time of Death

12:35 pm

4a. Facility Name (If not institution, give street and number)

Northampton Manor Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

220-78-6703

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept 18, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Myersville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2736 Monument Road

10f. Zip Code

21773

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Ammie Himes

19a. Informant's Name/Relationship (Type, Print)

Gay Ann Harper

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 101, Myersville, Maryland 21773

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Pleasant Walk U.Meth Cemt

Date

3-10-97

20c. Location - City or Town, State

Myersville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

504 Main Street  
Ricketts Funeral Home Myersville, MD 21773

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 mo

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

20 yrs

c. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

20 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 17106

29d. Date signed (Month, Day, Year)

March 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL S. RUDMAN MD 300 S. CHURCH ST. MIDDLETOWN, MD 21769

31. Date filed (Month, Day, Year)

MAR 07 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09195

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

YVONNE Mae STEPHENSON

2. Date of Death

Month Day Year  
MARCH 4, 1997

3. Time of Death

11:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

216-38-0437

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 16, 1935 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick10c. City, Town or Location  
Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

700 Motter Avenue

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

John Dayton Hite

18. Mother's Name (First, Middle, Maiden Surname)

Glennie Tederick

19a. Informant's Name/Relationship (Type, Print)

Mary R. Johnson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10856-E Highland School Rd. Myersville, Maryland 21773

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory

Date

Mar. 6, 1997 Smithsburg, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert W. Keeney MO0652

22. Name and Address of Facility

Keeney & Basford Funeral Home, 10 E.  
Church Street23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1 week

year

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial flutter

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

A. M. Smith

29c. License number

D26516

29d. Date signed (Month, Day, Year)

MARCH 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Gilman MD 147 STANLEY AVE FRED MD 21702

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 06 1997

32. Registrar's Signature

A. M. Smith

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

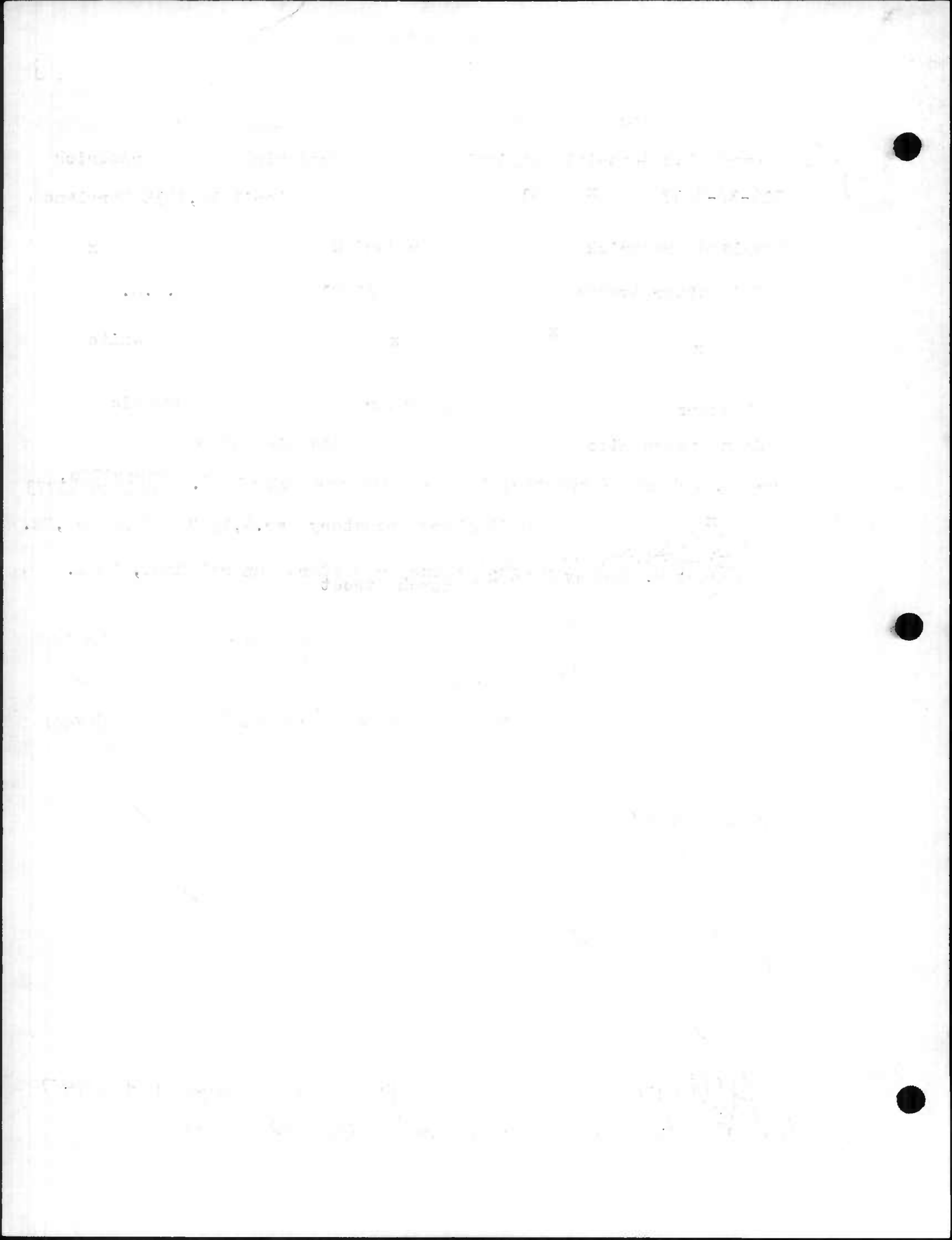
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09196

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley Earnest Smith				2. Date of Death Month Day Year March 1, 1997		3. Time of Death 6:01 P.M.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 226-50-9554	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 15, 1937		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State W. Va.	10b. County Jefferson	10c. City, Town or Location Harpers Ferry			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number Route 1, Box 434			10f. Zip Code 25425		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Homemaker				
	17. Father's Name (First, Middle, Last) Gaylord Thomas Earnest, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Cora Lynch				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Orville E. Smith, Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1, Box 434 - Harpers Ferry, WV 25425					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Birch Lawn Cemetery		Data 3/5/97		20c. Location - City or Town, State Pearisburg, Virginia		
	21. Signature of Funeral Service Licensee Robert L. Spencer			22. Name and Address of Facility Eackles-Spencer Funeral Home Harpers Ferry, WV 25425					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Pulmonary Embolism Due to (or as a consequence of): b. Status post left leg amputation Due to (or as a consequence of): c. Secondary infection of left leg stump Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death minutes	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Insulin dependent diabetes mellitus, malnourishment, Left Ventricular hypertrophy and severe hypokinesia							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 601 PM		28b. Time of Injury 601 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Christopher Fleming, M.D.		29c. License number 037178		29d. Date signed (Month, Day, Year) 3-2-97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Fleming, M.D. - 610 9th Avenue - Brunswick, MD 21716									
31. Date filed (Month, Day, Year) MAR 03 1997		32. Registrar's Signature Julia Andrew-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09197

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wayne Keith Sawyer				2. Date of Death Month Day Year March 13, 1997		3. Time of Death 3:30 AM	
	4a. Facility Name (If not institution, give street and number) 1219 Race Street				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 219-82-7081		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 33 Yrs.		8. Date of Birth (Month, Day, Year) Oct 24, 1963	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1219 Race Street		10f. Zip Code 21613		10g. Citizen of What Country? US	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator		16b. Kind of Business/Industry Publishing Company			
	17. Father's Name (First, Middle, Last) James Sawyer				18. Mother's Name (First, Middle, Maiden Surname) Sharon Trice Hamilton			
	19a. Informant's Name/Relationship (Type, Print) Bonnie J. Sawyer Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 Race Street Cambridge, Maryland 21613			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) East New Market Cemetery		20c. Date 3/17/97		20d. Location - City or Town, State East New Market, MD	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Respiratory Failure</u> Due to (or as a consequence of): b. <u>Lung Metastases</u> Due to (or as a consequence of): c. <u>Hodgkin's Disease</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 72hr 1 yr 4 yr			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of		29c. License number D33622		29d. Date signed (Month, Day, Year) 3-13-97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C CALDWELL, 2 AURORA ST, CAMBRIDGE, MD								
31. Date filed (Month, Day, Year) MAR 14 1997		32. Registrar's Signature John Andrew Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09/98

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Shepherd

2. Date of Death

March 21 1997

3. Time of Death

737AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

016 05 4675

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

JUNE 2, 1916

MASSACHUSETTS

Usual Residence of Decedent

10e. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

TAKOMA PARK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7705 TAKOMA AVENUE

10f. Zip Code

20912

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

RESEARCH DEVELOPMENT

17. Father's Name (First, Middle, Last)

EDWARD REAGAN

18. Mother's Name (First, Middle, Maiden Surname)

AURILA BURKE

19e. Informant's Name/Relationship (Type, Print)

JAMES E. SHEPHERD, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7705 TAKOMA AVENUE, TAKOMA PARK, MD. 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY 3/26/97

Date

20c. Location - City or Town, State

SILVER SPRING, MD.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME

P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Muriel H. Barber, MD

29c. License number

D33261

29d. Date signed (Month, Day, Year)

March 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Dr. Rockville MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 09199

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marjory Savich Thrasher				2. DATE OF DEATH MONTH DAY YEAR March 6, 1997		3. TIME OF DEATH 9:20 PM M	
4. SOCIAL SECURITY NUMBER 312-52-6037		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 49 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sep. 7, 1947		8. BIRTHPLACE (State or Foreign Country) Texas	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 10401 Sweetbrier Parkway				10f. ZIP CODE 20903		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Theodore Rudolph Savich				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elisabeth McNair			
19a. INFORMANT'S NAME (Type/Print) Gerald R. Trasher, Jr./Husband				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10401 Sweetbrier Parkway, Silver Spring, MD 20903			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery 3/13		20c. LOCATION — City or Town, State Adelphi, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. SEPTIC SHOCK DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 1 DAY	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. PULMONARY HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF):				3 WKS	
		c. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):				6 WKS	
		d. CHRONIC LYMPHOCYTIC LEUKEMIA				10 YRS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PANCYTOPENIC HYPOGAMMAGLOBULINEMIA							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Linda M Burrell MD				29c. LICENSE NUMBER D35996		29d. DATE SIGNED (Month, Day, Year) 03-07-97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINDA M BURRELL MD 2101 MEDICAL PARK DRIVE #210 SILVER SPRING, MD							
31. DATE FILED (Month, Day, Year) MAR 12 1997				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendall 20902			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09200

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Wainwright Turpin

2. Date of Death

March 9, 1997

3. Time of Death

1:00 P.M.

4a. Facility Name (If not institution, give street and number)

Collington Life Care

4b. City, Town, or Location of Death

Mitchelville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-60-2257

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 24, 1905

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchelville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10450 Lottsford Road

10f. Zip Code

20721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Walter S. Turpin

18. Mother's Name (First, Middle, Maiden Surname)

Louisa Wainwright

19a. Informant's Name/Relationship (Type, Print)

Peter Moseley/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

280 Golden Hills Drive Portola Valley, CA 94025

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Comfort Crematory

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.  
5130 Wisconsin Avenue NW  
Washington, D.C. 2001623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 Week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25079

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Don H. Yablonowitz, M.D. 7404 Executive Place #502 Seabrook, MD 20706

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

Julia Davidson-Rodale

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09201

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ABRAM TYLIMZUGER

2. Date of Death

Month Day Year  
MARCH 10, 1997

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

COLLEGE VIEW CTR. NURSING HOME

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

218-23-1486

6. Sex

15 M 20 F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
APRIL 29, 1915

9. Birthplace (State or Foreign Country)

UKRAINE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

1X Yes 20 No

10e. Street and Number

700 TOLLHOUSE AVENUE

10f. Zip Code

21701

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TECHNICIAN

16b. Kind of Business/Industry

ELECTRONIC

17. Father's Name (First, Middle, Last)

MARK TYLIMZUGER

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER SIRATA

19a. Informant's Name/Relationship (Type, Print)

BROKHA MARCHEV (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20139 HOB HILL WAY - GAITHERSBURG, MARYLAND 20879

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESD SHL EMMES CEM. 3/11/97

Date

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBROVASCULAR ACCIDENT

Approximate Interval Between Onset and Death

MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 10 Yes 20 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D26516

29d. Date signed (Month, Day, Year)

MARCH 11, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ALLEN J. GILSON, MD - 1475 TANEY AVENUE - FREDERICK, MARYLAND 21702

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09202

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Douglas H. Tretler				2. Date of Death Month: March Day: 11, Year: 1997		3. Time of Death 12:50 PM		
	4a. Facility Name (If not institution, give street and number) 10000 Brunswick Ave., Apt. 514				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579-14-3269		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 14, 1920		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 10000 Brunswick Avenue, Apt. 514		10f. Zip Code 20910		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Binder		16b. Kind of Business/Industry Graphic Communications					
17. Father's Name (First, Middle, Last) Harry U. Tretler				18. Mother's Name (First, Middle, Maiden Surname) Sara Ann Guyther					
19a. Informant's Name/Relationship (Type, Print) Helen T. Jordan				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3433 South Leisure World Blvd., Silver Spring, MD 20906					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Date 3/14/97		20d. Location - City or Town, State Silver Spring, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd., W. Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier 	
		29c. License number D25080		29d. Date signed (Month, Day, Year) 3/12/97					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Frank N. Gravino, 10313 Georgia Ave, Silver Spring, MD									
31. Date filed (Month, Day, Year) MAR 14 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09203

Items; 23 part i, 27 per MEO G-747 5/29/97 <sup>resh</sup> Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KYREE COURTEACE TWINE</b>		2. Date of Death Month Day Year <b>MARCH 03 1997</b>		3. Time of Death <b>3:18 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>		4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>213-49-2240</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <b>3</b> Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 27, 1996</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>62 West Deer Park Road</b>		10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>None</b>		16b. Kind of Business/Industry <b>N/A</b>	
	17. Father's Name (First, Middle, Last) <b>Alexander Twine</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nicole Fleming</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Nicole Fleming/Mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>62 West Deer Park Rd., Gaithersburg, MD. 20877</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Location - City or Town, State <b>3/7/97 Silver Spring, MD.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DeVol Funeral Home</b> <b>10 East Deer Park Dr., Gaithersburg, MD. 20877</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>SUDDEN INFANT DEATH SYNDROME</b> Due to (or as a consequence of): a. b. c. d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MARCH 05, 1997</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARGARET A. KORONAKIS 111 Penn Street, Baltimore, Maryland 21201</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>MAR 13 1997</b>		32. Registrar's Signature 			



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State of Maryland / Department of Health and Mental Hygiene

97 09204

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wilbert Mackay Tippet</b>			2. Date of Death Month <b>March</b> Day <b>10</b> Year <b>1997</b>		3. Time of Death <b>6<sup>02</sup> pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>			4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>214-12-7854</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT. 6, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2829 MUNSON STREET</b>		10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942 - 1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MEATCUTTER</b>		16b. Kind of Business/Industry <b>SAFEWAY FOODS</b>		17. Father's Name (First, Middle, Last) <b>SAMUEL E. TIPPETT</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>GRACE M. RICHARDS</b>		19a. Informant's Name/Relationship (Type, Print) <b>MILDRED L. TIPPETT - WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2829 MUNSON STREET, SILVER SPRING, MD. 20902</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS' CEM. MARCH 14, 1997, CHELTENHAM, MD</b>		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee <b>MARK G. BROHAWN MO0053</b>		22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Lymphoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>6 months</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Peter B. Sherer MD</b>		29c. License number <b>021910</b>		29d. Date signed (Month, Day, Year) <b>March 11, 1997</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Peter B. Sherer MD 3947 Ferrara Dr Wheaton, MD 20906</b>		31. Date filed (Month, Day, Year) <b>MAR 17 1997</b>		32. Registrar's Signature <b>Sandra D. ...</b>			



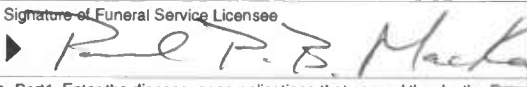
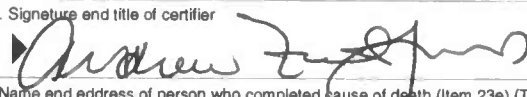
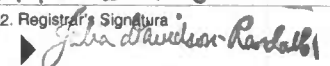
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09205

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Janice Mae Thomas</b>				2. Date of Death Month <b>March</b> Day <b>2</b> Year <b>1997</b>		3. Time of Death <b>1:48 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>219-36-3102</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 9, 1940</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>John Hanson Apartments # 25</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>self</b>				
17. Father's Name (First, Middle, Last) <b>James Copeland</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sadie Monroe</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Donald N. Thomas / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>427 N. Franklin St., Hanover, PA 17331</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ebenezer Cemetery</b>		20c. Date <b>3/5/97</b>		20d. Location - City or Town, State <b>Ijamsville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 621 Opossumtown Pike, Frederick, MD 21702</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ASCVD</b> Due to (or as a consequence of): b. <b>Congestive Heart Failure</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>Years</b> <b>days</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D35164</b>		29d. Date signed (Month, Day, Year) <b>March 2, 1997</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Andrew Zaruck, Jr., MD 1080 W. Patrick St Frederick, MD 21703</b>								
31. Date filed (Month, Day, Year) <b>MAR 05 1997</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

97 09206

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond V. Ulrich				2. Date of Death Month Day Year March 12, 1997		3. Time of Death 11:32 AM	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 341-10-3513	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 7, 1910		9. Birthplace (State or Foreign Country) Illinois
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3301 Hampton Point Drive, #B				10f. Zip Code 20904		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Transit Worker		16b. Kind of Business/Industry Chicago Transit Authority			
	17. Father's Name (First, Middle, Last) Emil J. Ulrich				18. Mother's Name (First, Middle, Maiden Surname) Emma Stronner			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Richard F. Ulrich				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Deer Ridge Drive, Silver Spring, MD 20904			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Date 3-14-97		20d. Location - City or Town, State Beltsville, Maryland	
	21. Signature of Funeral Service Licensee Eileen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 12-29-96		28b. Time of Injury 3:00 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred Fell getting into bed				28e. Location (Street and Number or Rural Route Number, City or Town, State) 3301-B Hampton Point Dr., Silver Spring, MD			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier John F. Tauber MD				29c. License number D08546		29d. Date signed (Month, Day, Year) March 13 1997	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John F. Tauber, M. D., 8218 Wisconsin Avenue, #318, Bethesda, MD 20814							
31. Date filed (Month, Day, Year) MAR 14 1997				32. Registrar's Signature Julia Davidson-Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09207

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARIAN VIRGINIA VANCE

2. Date of Death

MARCH 14, 1997

3. Time of Death

0445am

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

178-28-8459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 1 1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

PA.

10b. County

BEDFORD

10c. City, Town or Location

CLEARVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RFD#3 BOX#310

10f. Zip Code

15535

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSE KEEPER

16b. Kind of Business/Industry

HOUSE KEEPER

17. Father's Name (First, Middle, Last)

MARVIN MORRAL

18. Mother's Name (First, Middle, Maiden Surname)

LONA KETTERMAN

19a. Informant's Name/Relationship (Type, Print)

GENE VANCE HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RFD#3 BOX#310 CLEARVILLE, PA. 15535

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLENDALE CEMETERY MARCH 17 1997

Date

20c. Location - City or Town, State

FLINTSTONE MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME  
404 DECATUR STREET CUMBERLAND MARYLAND23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Renal failure  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

4 weeks

b. hypercalcemia  
Due to (or as a consequence of):

4 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastc. Progressive IgA myeloma  
Due to (or as a consequence of):

17 years

d. severe Pancytopenia

6 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John McRae MD

29c. License number

D-17526

29d. Date signed (Month, Day, Year)

MARCH 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEHANNA, JOHN, M.D. 909-B SETON DRIVE CUMBERLAND, MD. 21502

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

John McRae MD

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09208

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Joseph Vanden Broecke

2. Date of Death

March 11 1997

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

041-32-5778

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

January 12, 1939

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

413 Maravista Court

10f. Zip Code

20905

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chairman of the Board

16b. Kind of Business/Industry

Property Management

17. Father's Name (First, Middle, Last)

Joseph Vanden Broecke

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Geeraert

19a. Informant's Name/Relationship (Type, Print)

Elyce H. Vanden Broecke

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 Maravista Court, Silver Spring, Maryland 20905

20a. Method of Disposition

XX Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Memorial Park

Date

3-13-97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc. 11800 New  
Hampshire Ave., Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

Pneumonia

3 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

Sepsis

c.

Due to (or as a consequence of):

Multiple Sclerosis

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending

investigation

6 Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMAD A KHALID MD. 8830 Cameron Court Suit 502 Silver Spring MD 20902

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09209

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY AIELLO VENDITTI

2. Date of Death

March 9, 1997

3. Time of Death

4:55PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Manor Care-Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

216-34-3357

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 24, 1906

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10655 Green Mountain Circle

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Beautician/Owner

16b. Kind of Business/Industry

Beauty Shop

17. Father's Name (First, Middle, Last)

Luigi Aiello

18. Mother's Name (First, Middle, Maiden Surname)

Maria Guiseppea Gigliatti

19a. Informant's Name/Relationship (Type, Print)

John M. Venditti/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6222 Stoneham Court, Bethesda, Maryland 20817

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

March 13, 1997

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

David E. Perry, M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin  
Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

ACUTE

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. ATHEROSCLEROSIS

Due to (or as a consequence of):

YEARS

c. HYPERTENSION

Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ORGANIC BRAIN SYNDROME -

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

28. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David E. Perry, M00803

29c. License number

D25422

29d. Date signed (Month, Day, Year)

MARCH 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT MACCIN, MD 14333 LAUREL BOULEVARD #307  
LAUREL, MD 20708

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #7, 3/14/97, JW, Montg. Cty.

## Certificate of Death

Reg. No.

97 09210

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lydia

2. Date of Death  
Month Day Year

Vizbulis

March 3 1997

3. Time of Death

9:20 A

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

229-44-9030

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

February 17, 1908

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2811 31st Street, S.E., #B-527

10f. Zip Code

20020

10g. Citizen of What Country?

Russia

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Publishing

17. Father's Name (First, Middle, Last)

Jacob Malchevsky

18. Mother's Name (First, Middle, Maiden Surname)

Minna not available

19a. Informant's Name/Relationship (Type, Print)

Dzidra N. Vizbulis / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5480 Wisconsin Avenue, #1413, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

March 6, 1997

Montgomery Crematorium, Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Barbara J. McMullen Lawrence

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

STROKE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

THROMBOEMBOLISM

Due to (or as a consequence of):

2 WEEKS

ATRIAL FIBRILLATION

Due to (or as a consequence of):

NOT KNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GI BLEED

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D35941

29d. Date signed (Month, Day, Year)

MARCH 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PURAN P. MATHEW #401 50 W. EDMONSTON DR. ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09211

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Audrey E. Welch</b>				2. Date of Death Month <b>March</b> Day <b>12</b> Year <b>1997</b>				3. Time of Death <b>12:31 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>531-20-7493</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>Jan. 12, 1924</b>		
	9. Birthplace (State or Foreign Country) <b>Washington</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>805 Downs Drive</b>				10f. Zip Code <b>20904</b>				10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Bernt Berntsen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Lerback</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Armond Welch / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>805 Downs Drive, Silver Spring, Maryland 20904</b>						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory</b>				20c. Location - City or Town, State <b>3/15/97 Brentwood, Maryland</b>		
	21. Signature of Funeral Service Licensee <i>Thomas J. Gregor</i>				22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home</b> <b>11800 New Hampshire Avenue</b> <b>Silver Spring, Maryland 20904</b>						
	23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary Embolism</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>3 Hrs</b>		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Arthur S. Bresler, M.D.</i>				29c. License number <b>DO 4418</b>		29d. Date signed (Month, Day, Year) <b>Mar 12, 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Arthur S. Bresler, M.D. 10881 Lockwood Drive, Silver Spring, Maryland 20901</b>				31. Date filed (Month, Day, Year) <b>MAR 14 1997</b>				32. Registrar's Signature <i>Julia Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200.

201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09212

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Maurice L. Walker

2. Date of Death

Month, Day, Year  
March 4, 1997

3. Time of Death

5:35 P.M.

4a. Facility Name (If not institution, give street and number)

Mariner Health Care

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-09-0811

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 2, 1913

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

513 Roxboro Place, N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Man

18b. Kind of Business/Industry

Lustine Motors

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Walker

19a. Informant's Name/Relationship (Type, Print)

Cozetta C. Walker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

513 Roxboro Place, N.W., Washington, D.C. 20011

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Cemetery

Date

3/10/97

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.  
7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41931

29d. Date signed (Month, Day, Year)

March 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

R Shumacher MD 2309 Shorefield Rd Wheaton MD 20902

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



97 09213

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOTTIE L. WINSTON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 - 01 - 97</b>  |  | 3. TIME OF DEATH<br><b>5:15A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>230-24-4696</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-31-1911</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PINEVIEW NURSING &amp; REHAB CENTRE</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON MD.</b>   |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>CLINTON, MD.</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>9106 PINEVIEW LANE</b>  |  |  |  | 10f. ZIP CODE<br><b>20785</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>office work</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unobtainable</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unobtainable</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rosemary L. Madden/Guardian</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5012 Rhode Island Ave. Hyattsville, MD 20781</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory Mar 10, 1997 Alexandria, VA</b>   |  | 20c. LOCATION - City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Takoma Funeral Home, Inc.<br/>254 Carroll St. NW Washington, DC 20012</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Acute myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>Sudden</b> |
|  |  | b. <b>Arteriosclerotic heart disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |   |
|  |  | c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |   |
|  |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>postlemon's disease, senile<br/>convulsive disorder</b>   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 15595</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>03/01/97</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HYO K. LEE MD 11010 LOCUST GLEN DR.</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 14 1997</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 09214**  
Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |   |   |
|--|--|---|--|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma M. Winters</b>                       |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>7</b> Year <b>1997</b> |  | 3. Time of Death<br><b>7:45 PM</b>                          |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>12137 Dove Circle</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>                |  | 4c. County of Death<br><b>Prince George's</b>               |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-20-4950</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 20, 1922</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|  | Usual Residence of Decedent  |   |  |  |  |  |   |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Hyattsville</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
| 10e. Street and Number<br><b>8516 14th Avenue</b>  |  |   |  | 10f. Zip Code<br><b>20783</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Retail</b>  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Menke</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nora Lipscomb</b>  |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Katherine W. Brungardt</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12137 Dove Circle Laurel, Maryland 20708</b>   |  |  |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>3/08/97</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |   |   |
| 21. Signature of Funeral Service Licensee<br><b>J. Kevin Gutowski</b>  |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W., Silver Spring, MD 20901</b>   |  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>INTRACEREBRAL HEMORRHAGE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>10 DAYS</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |   |   |
| 29b. Signature and title of certifier<br><b>Charles M. Benner MD</b>   |  |   |  | 29c. License number<br><b>D31563</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 8, 1997</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Charles M. Benner, M.D. 11251 Lockwood Drive Silver Spring, Maryland 20901</b>  |  |   |  |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 11 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>J. Davidson-Randall</b>  |  |  |   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09215

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RITA

WILSON

2. Date of Death  
Month Day Year  
MARCH 4, 19973. Time of Death  
4:10 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

10718 POTOMAC TENNIS LANE COURT

4b. City, Town, or Location of Death

POTOMAC

4c. County of Death

MONTGOMERY

5. Social Security Number

100-32-4064

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 14, 1906

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10718 POTOMAC TENNIS LANE COURT

10f. Zip Code

20854

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

MYER SPIVAK

18. Mother's Name (First, Middle, Maiden Surname)

GALE UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

EDWARD C. GILBERT SON-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9706 LOGAN DRIVE, POTOMAC, MARYLAND 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKLAWN MEMORIAL PARK

Date

3/8/97

20c. Location - City or Town, State

ROCKVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH GAWLER'S SONS, INC.  
5130 WISCONSIN AVENUE, NW  
WASHINGTON, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

b. OLD AGE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accidental 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRAUKE WESTPHAL, M.D. 809 VEIRS MILL ROAD #101, ROCKVILLE, MD 20851

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09216

Certificate of Death

Reg. No.

|   |  |   |  |   |  |   |   |  |
|---|--|---|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>William Francis Watts</u>   |   |  |   | 2. Date of Death<br>Month <u>March</u> Day <u>03</u> Year <u>1997</u>  |   | 3. Time of Death<br><u>1:40 PM</u>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Fallston General Hospital</u>   |   |  |   | 4b. City, Town, or Location of Death<br><u>Fallston</u>  |   | 4c. County of Death<br><u>Harford</u>                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>218-32-4575</u>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><u>60</u> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><u>Feb. 13, 1937</u>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |   | 10a. State<br><u>Maryland</u>  |   | 10b. County<br><u>Harford</u>  |   | 10c. City, Town or Location<br><u>Edgewood</u>                          |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><u>330 Laburnum Rd.</u>  |   | 10f. Zip Code<br><u>21040</u>  |   | 10g. Citizen of What Country?<br><u>USA</u>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>u/k</u> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Lineworker</u>                               |   | 16b. Kind of Business/Industry<br><u>Auto Manufacturing</u>  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>James Thomas Watts, Sr.</u>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Elizabeth Emma Clark</u>   |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Odette C. Watts - Wife</u>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>330 Laburnum Rd., Edgewood, Md. 21040</u>  |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Bel Air Memorial Gardens</u>  |   | Date<br><u>3-7-97</u>  |   | 20c. Location - City or Town, State<br><u>Bel Air, Maryland</u>         |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Howard K. McComas III</u>  |   |  |   | 22. Name and Address of Facility<br><u>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, Md. 21009</u>  |   |   |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>Multiorgan system failure.</u><br>Due to (or as a consequence of):<br><u>Septic</u><br>Due to (or as a consequence of):<br><u>Peritonitis</u><br>Due to (or as a consequence of):<br><u></u><br>Due to (or as a consequence of):<br><u></u><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u></u> |   |  |   | Approximate Interval Between Onset and Death<br><u>2 weeks</u><br><u>3 weeks</u><br><u>3 weeks</u>   |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Cerebrovascular accident</u><br><u>Diabetes Mellitus</u>  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 24b. Were autopsy findings evaluable prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><u></u>   |  | 28b. Time of Injury<br><u>M</u>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred<br><u></u>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u></u>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u></u> |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><u>PETER LORESTI, DO FAC</u>   |  | 29c. License number<br><u>H39022</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>MARCH 3 1997</u>                                  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>PETER LORESTI, DO FAC 1308 BUSINESS CENTER WAY EDGEWOOD MD</u>   |  | 31. Date filed (Month, Day, Year)<br><u>MAR 11 1997</u>   |  |   |  |   |   |  |
| 32. Registrar's Signature<br><u>John Andrew Randall</u>   |  |   |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09217

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BYRT --- WALLEY

2. Date of Death

Month Day Year  
MAR 10 1997

3. Time of Death

1315pm

4a. Facility Name (If not institution, give street and number)

1324 GERMANDER DR

4b. City, Town, or Location of Death

BELCAMP, MD

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

587-23-5300

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 27, 1960

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Belcamp

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1324 Germander Dr.

10f. Zip Code

21017

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1981 -

1997

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Military

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Fletcher --- Walley, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Doris --- Coleman

19a. Informant's Name/Relationship (Type, Print)

Cynthia L. Walley - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1324 Germander Dr., Belcamp, MD 21017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cem.

Date

3-13-97

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, Md. 21009

23a. Part I: Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

METASTATIC COLON CANCER

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD

31. Date filed (Month, Day, Year)

MAR 14 1997

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09218

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Yvonne LaRue WILLS

2. Date of Death

March 10, 1997

3. Time of Death

8:45 AM

4a. Facility Name (If not Institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

213-24-8845

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 20, 1930

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

XX  
1 ☒ Yes 2 ☐ No

10e. Street and Number

344 North Market Street

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert

UNGLEBOWER

18. Mother's Name (First, Middle, Maiden Surname)

Effie

SMITH

19a. Informant's Name/Relationship (Type, Print)

Mrs. Patricia Hall, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9300 Granite Circle, Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Olivet Cemetery, March 12, 1997

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard E. Graf MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home  
106 East Church St., Frederick, Maryland 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease 10yrs

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia (Alzheimer's)

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Allen J. Gilsen

29c. License number

D26516

29d. Date signed (Month, Day, Year)

March 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Gilsen 1475 TANEY Ave Fred MD 21702

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



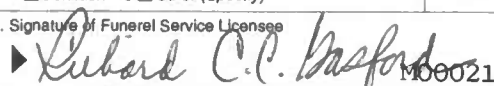
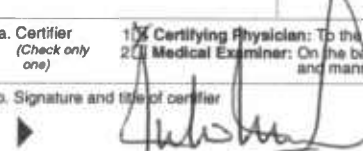
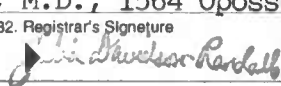
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09219

## Certificate of Death

Reg. No.

|   |  |                                       |   |   |   |  |   |  |
|---|--|---------------------------------------|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mae Elizabeth WHISNER</b>   |                                       |   |   | 2. Date of Death<br>Month Day Year<br><b>March 8, 1997</b>  |  | 3. Time of Death<br><b>2:55 A.M.</b>                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>College View Center</b>   |                                       |   |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  | 4c. County of Death<br><b>Frederick</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-10-5401</b>  |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 23, 1910</b>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |                                       |   |   |   |  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |                                       |   |   |   |  |   |  |
|   | 10a. State<br><b>Maryland</b>  |                                       | 10b. County<br><b>Frederick</b>   |   | 10c. City, Town or Location<br><b>Frederick</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>307 Center Street</b>   |                                       |   | 10f. Zip Code<br><b>21701</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Fred Mills, Sr.</b>  |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Clapsaddle</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris Ropp/ Daughter</b>  |                                       |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>441 Carrollton Drive, Frederick, Maryland 21701</b>   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>  |   | Date<br><b>March 11, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Frederick, Md.</b>            |  |
|   | 21. Signature of Funeral Service Licensee<br>  |                                       |   |   | 22. Name and Address of Facility<br><b>Keeney and Basford Funeral Home</b><br><b>106 East Church Street, Frederick, Md. 21701</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASCVD</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>10 y1)</b> |                                       |   |   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>CVA</b>   |  |                                       |   |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |                                       |   |   |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                       |   |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                       |   |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                       |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  |                                       |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                       |   |   |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                       |   |   |   |  |   |  |
| 29b. Signature and title of certifier<br>  |  |                                       |   | 29c. License number<br><b>D31912</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 11, 1997</b>                         |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Julio J. Menocal, M.D., 1564 Opossumtown Pike, Frederick, Md. 21702</b>  |  |                                       |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 11 1997</b>   |  |                                       |   | 32. Registrar's Signature<br>  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09220

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |   |
|---|--|--|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ALYCE VIRGINIA WHITE</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 4, 1997</b>   |  | 3. Time of Death<br><b>10:30 PM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>  |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-05-6404</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 28, 1918</b>  |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Frederick</b>  |   |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>College View Center<br/>400 North Avenue</b>   |  | 10f. Zip Code<br><b>21701</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk/Typist</b>  |  | 16b. Kind of Business/Industry<br><b>B&amp;O Railroad</b>  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Dorsey Lee Riddlemoser</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Talmadge Biggs</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judy Stashik/Friend</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7002 Runnymede Court, Frederick, Maryland 21702</b>                                      |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>  |  | 20c. Date<br><b>3/10</b>   |  | 20d. Location - City or Town, State<br><b>Frederick, Maryland</b>  |   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.<br/>1201 NORTH MARKET ST. FREDERICK, MD 21701</b>  |  |  |   |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia left lung</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b> |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>11 weeks</b> |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>DO 7186</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 7, 1997</b>  |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Philip Shapiro, MD 814 Toll House Avenue, Frederick, Maryland 21701</b>   |  |   |  |  |  |  |   |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 07 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |   |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09221

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CORDELIA

M.

WILLIAMS

2. Date of Death

MARCH 20, 1997

3. Time of Death

4:09 A.M.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

160-16-0117

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 23, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

York

10c. City, Town or Location

York

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

611 S. Queen St.

10f. Zip Code

17403

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Seven

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Cafe

17. Father's Name (First, Middle, Last)

Henry Markle

18. Mother's Name (First, Middle, Maiden Surname)

Martha Eaton

19a. Informant's Name/Relationship (Type, Print)

Betsy Swift / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

611 S. Queen St. York PA 17403

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Rose Cemetery

Date

March 24, 1997

20c. Location - City or Town, State

York, PA

21. Signature of Funeral Service Licensee

George J. Cuilla

22. Name and Address of Facility

John W. Keffer Funeral Home, Inc.

902 Mt. Rose Ave. York PA 17403

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Thoracoabdominal Aortic Aneurysm

Due to (or as a consequence of):

Several years

c. Previous myocardial infarction

Due to (or as a consequence of):

16 years

d. Severe coronary artery disease

Several years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Senior ICU Resident

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

March 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan M. Winograd, 2726 Valley Park Drive, Baltimore, Md. 21209

31. Date filed (Month, Day, Year)

MAR 26 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09222

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marietta Burckett Yancey

2. Date of Death

March 8, 1997

3. Time of Death

10:35 AM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

1812 Powder Mill Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

439-64-1766

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 27, 1944

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1812 Powder Mill Road

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Congressional Affairs for foreign Agri. Serv.

16b. Kind of Business/Industry

U.S. Dept. of Agriculture

17. Father's Name (First, Middle, Last)

Milton Boarman Burckett

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Walker

19e. Informant's Name/Relationship (Type, Print)

Ernest V. Yancey / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1812 Powder Mill Road, Silver Spring, MD 20903

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem. 3/14/97 Arlington, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pulmonary disease secondary to breast cancer

6 wks.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Breast Cancer

3 yrs.

Due to (or as a consequence of):

c. Pericardial + pleural effusions

6 wks.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A (none)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

N/A

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John M. Hildner

29c. License number

#18870 (P.S.)

29d. Date signed (Month, Day, Year)

03/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.M. Hill, MD, NMMC, 8901 Wisconsin Ave. (Dept. 1), Bethesda, MD 20887-5800

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09223

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>TYRONE BRAHAM</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>March 26, 1997</b>  |  | 3. Time of Death<br><b>11:30 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-76-0697</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 22, 1959</b>                    |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Balto, Md.</b>  |  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>                                  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1040 N. Stricker St.</b>   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> Collage (1-4 or 5+) <input checked="" type="checkbox"/> <b>3 yrs</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>                          |  | 16b. Kind of Business/Industry<br><b>Restaurant.</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>George Braham</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosa Lee Neal</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosa Lee Neal / Mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2499 Druid Hill Ave. Balto, Md. 21217</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus</b>  |  | 20c. Location - City or Town, State<br><b>Balto, Md.</b>   |  | 20d. Date<br><b>4/2/97</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>James A. Morton</b>  |  |   |  | 22. Name and Address of Facility<br><b>James A. Morton &amp; Sons<br/>1701 Laurens St. Balto, Md. 21217</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME yrs.</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PERIPHERAL NEUROPATHY</b>   |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br><b>Kendall Faulkner</b>   |  |   |  | 29c. License number<br><b>025643</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/27/97</b>                            |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. KENDALL FAULKNER, 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>   |  |   |  |  |  |  |  |
|   | 31. Date<br><b>MAR 27 1997</b>   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09224

ITEM: 17,24a per DR.&amp;FH G-745 3-27-97 eoh Certificate of Death

Reg. No.

|  |  |                                 |   |  |  |  |   |  |   |
|--|--|---------------------------------|---|--|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Paul A. Brent</i>   |                                 |   | 2. Date of Death<br>Month <i>03</i> Day <i>11</i> Year <i>97</i>   |  |  | 3. Time of Death<br><i>02<sup>05</sup> a.m.</i>   |  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Shock Trauma Center</i>   |                                 |   | 4b. City, Town, or Location of Death<br><i>Baltimore, M.D.</i>   |  |  | 4c. County of Death<br><i>Baltimore County</i>  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>217-24-4721</i>  |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>70</i> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>03/04/27</i>                                      |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |
|  | Usual Residence of Decedent  |                                 |   |  |  |  |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><i>MD</i>  | 10b. County<br><i>Baltimore</i> | 10c. City, Town or Location<br><i>Baltimore</i>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |
|  | 10e. Street and Number<br><i>2401 St. Stephens Court</i>   |                                 |   | 10f. Zip Code<br><i>21216</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |   |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>Jan 1947 - May 1948</i>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                     |  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Teacher</i>   |  | 16b. Kind of Business/Industry<br><i>School</i>  |  |   |  |   |
|  | 17. Father's Name (First, Middle, Last) <i>SR. Howard D. Brent, Dr.</i>  |                                 |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Lavinia Clash</i>  |  |  |   |  |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>William A. Brent brother</i>  |                                 |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>155 Abington Avenue, Baltimore, Maryland 21229</i> |  |  |   |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | Date   | 20c. Location - City or Town, State   |  |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Joseph B. Van Sant</i>   |                                 |   | 22. Name and Address of Facility<br><i>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</i>                                  |  |  |   |  |   |
|  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                                 |   |  |  |  |   |  | Approximate Interval Between Onset and Death                |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cerebral herniation</i><br>Due to (or as a consequence of):<br>b. <i>Massive intracerebral hemorrhage</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                 |   |  |  |  |   |  | <i>24 hours</i>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                 |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |   |
|  |  |                                 |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |
|  |  |                                 |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |                                 | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |
|  |  |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                 |   |  |  |  |   |  |   |
| 29b. Signature and title of certifier<br><i>Boulier</i>  |  |                                 | 29c. License number<br><i>D 44498</i>   |  |  | 29d. Date signed (Month, Day, Year)<br><i>03/11/97</i>   |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>BRET BORCHERT, MD 22 S. GREENE ST BALTIMORE, MD 21201</i>   |  |                                 |   |  |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><i>MAR 27 1997</i>  |  |                                 | 32. Registrar's Signature<br><i>Davidson-Rendell</i>  |  |  |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09225

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irvin Brown

2. Date of Death

March 24 1997

3. Time of Death

12:20 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

JOSEPH RICHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

29-01-6963

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 15, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1701 N. Eutam Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Supervisor

16b. Kind of Business/Industry

Social Security Administration

17. Father's Name (First, Middle, Last)

IRVIN A. BROWN, SR.

18. Mother's Name (First, Middle, Maiden Surname)

RACHAEL Cooper

19a. Informant's Name/Relationship (Type, Print)

Elsie Farmer Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1600 W. Mt. Royal Ave. Baltimore, Md 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Barrison Forest Veterans Cem. 3/31/97

Date

3/31/97

20c. Location - City or Town, State

Owings Mills Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHAYMAN - HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer

Approximate Interval Between Onset and Death

15+ years

Due to (or as a consequence of):

b. Chronic obstructive pulmonary disease

?

Due to (or as a consequence of):

c. brain metastases

1 year

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cellulitis of legs

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D 13006

29d. Date signed (Month, Day, Year)

25 Mar 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas H. Powell 101 W. Read St. Baltimore 21201

31. Data filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09226

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Malvin Brown

2. Date of Death

March 26, 1997

3. Time of Death

12:40PM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

N/A

4c. County of Death

Fallston

5. Social Security Number

212-26-2952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB 25, 13

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10e. State

MD

10b. County

HARFORD

10c. City, Town or Location

TOPPA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2023 SINGER ROAD

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5th

College (1-4 or 5+)

N/A

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAL

16b. Kind of Business/Industry

ENOCH Pratt LIBRARY

17. Father's Name (First, Middle, Last)

WILLIAM BROWN

18. Mother's Name (First, Middle, Maiden Surname)

ELMINA AUSTIN

19e. Informant's Name/Relationship (Type, Print)

MABLE BROWN/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2023 SINGER Rd - TOPPA, MD 21085

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

COMMUNITY BAPTIST CH. Cem

Date

3/29/97 TOPPA, MD 21085

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

BETTS FUNERAL HOME  
1129 W. CAROLINE ST - BALTO, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute on Chronic Respiratory Failure weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Status Asthmaticus weeks

Due to (or as a consequence of):

c. Chronic Bronchial Asthma years

Due to (or as a consequence of):

d. Hypertension years

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease  
Esophageal Reflux Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Albert S.C. Sun, M.D.

29c. License number

MD-D18779

29d. Date signed (Month, Day, Year)

March 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ALBERT S.C. SUN, M.D. 1800 HARFORD ROAD, FALLSTON, MD 21047

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

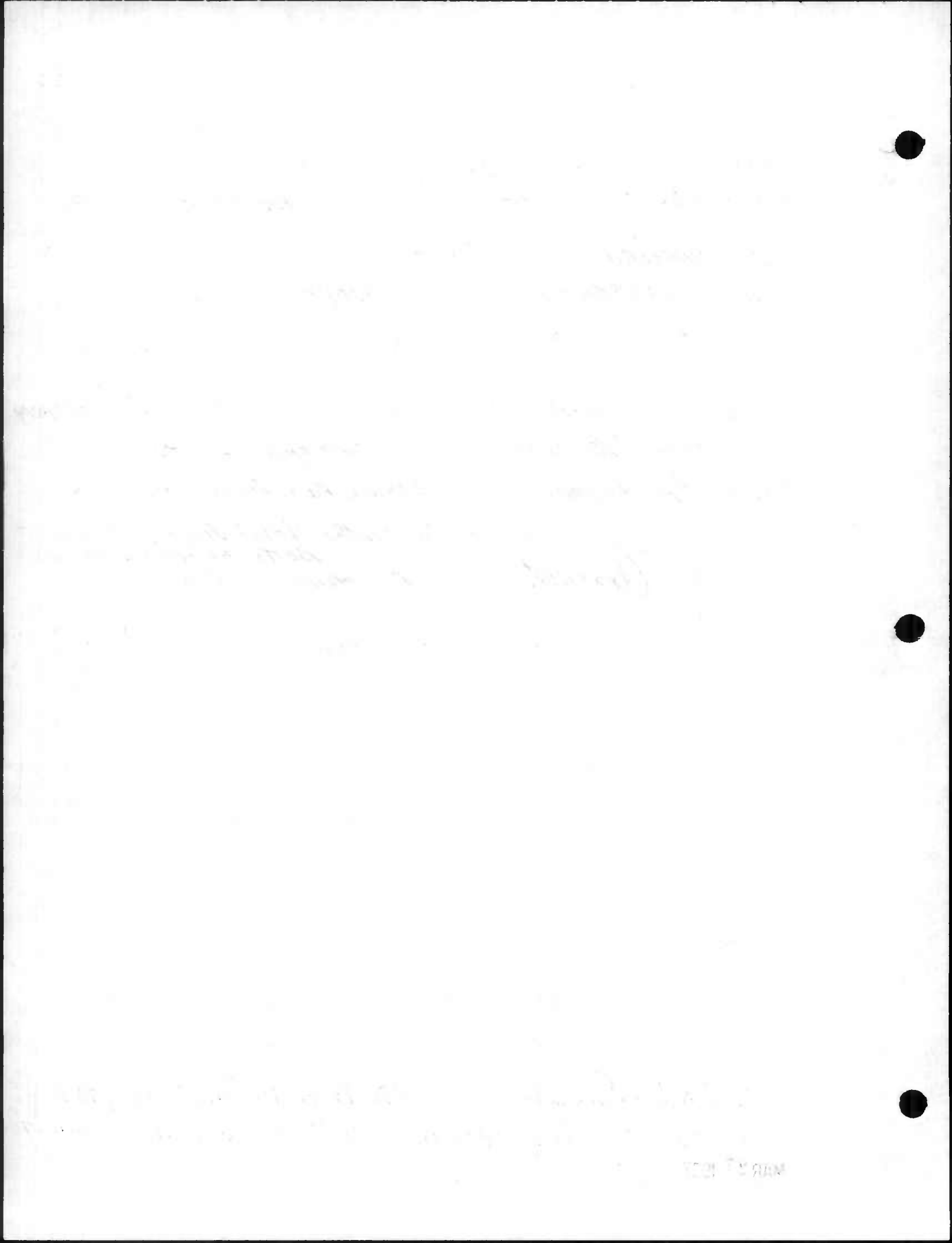
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09227

Reg. No.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WESLEY G. BROWN</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>23</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2330 P</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3130 W. NORTH AVE</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>NA</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-17-0248</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>20</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>1-27-1977</b>      |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |
|  | 10e. Street and Number<br><b>3334 Piedmont Avenue</b>   |  | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>1yr</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NA</b>                            |  | 16b. Kind of Business/Industry<br><b>NA</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Wilbur Brown, Jr</b>  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>EMogene Sherod</b>  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Wilbur + EMogene Brown - Parents</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3334 Piedmont Avenue Baltimore, MD 21216</b>  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>3-29-97 Randallstown, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Gale March</b>  |  | 22. Name and Address of Facility<br><b>March F. H. West<br/>4300 Wabash Avenue Balto, MD 21215</b>  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Multiple Gunshot Wounds</b>  |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>FIREHOUSE</b>   |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>3-23-97</b>   |   |  |   |  |  |
| 28b. Time of Injury<br><b>UNK</b> M  |   |  |   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |
| 28d. Describe how injury occurred.<br><b>Subject shot</b>  |   |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>UNK</b>   |   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>UNK</b>   |   |  |   |  |  |
| 29a. Certifier (Check one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Carla Labe MD</b>  |   | 29c. License number<br><b>O.C.M.E</b>                                      |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Salon Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |   | 32. Registrar's Signature<br><b>Julia Burdson-Rodella</b>                  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09228

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VALERIE

2. Date of Death

Month

Day

Year

MARCH 22, 1997

3. Time of Death

11:00 PM

4e. Facility Name (If not institution, give street and number)

PRINCE GEORGES" HOSP. CENTER

4b. City, Town, or Location of Death

CHERVERLY

4c. County of Death

PRINCE GEORGES CO.

Funeral  
Director

5. Social Security Number

220-24-2971

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR. 06, 1903

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE

10c. City, Town or Location

BOWIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

26 N KOSSUTH ST.

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: NEGROE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

N/A

2 YEARS

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

VIRGINIA PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

WALLY KING

18. Mother's Name (First, Middle, Maiden Surname)

LUCY MC CLAIN

19a. Informant's Name/Relationship (Type, Print)

MARIAN BOWMAN -NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8911 CRANDALL RD. LATHAM, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MAR. 26, 1997  
MARYLAND NATIONAL MEM. PK. LAUREL, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET, BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or Injury

that initiated events

resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR  
DISEASE WITH AORTIC STENOSIS  
DEEP VEIN THROMBOPHLEBITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and Title of Certifier

William D. Rosson, M.D.

29c. License number

D 16897

29d. Date signed (Month, Day, Year)

MARCH 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WILLIAM D. ROSSON, M.D. 5701 85TH AVE. NEWCARROLLTON, MD. 20784

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

March 22 1937

1937

1937

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. Some fragments are visible, such as "The following is a list of the", "The following is a list of the", and "The following is a list of the".]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09229

## Certificate of Death

Reg. No.

|   |  |  |   |                                 |   |
|---|--|--|---|---------------------------------|---|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><i>Sylvia Cohen</i>  |  | 2. Date of Death<br>Month <i>March</i> Day <i>22</i> Year <i>1997</i>   |                                 | 3. Time of Death<br><i>10:15 am</i>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                 | 4c. County of Death<br><b>N/A</b>   |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>103-20-1071</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 24, 1924</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>   |                                 |   |
| To Be Completed by Funeral Director                     | Usual Residence of Decedent  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 10a. State<br><b>MARYLAND</b>  | 10b. County<br><b>N/A</b>  |   |                                 |   |
|   | 10e. Street and Number<br><b>5717 UFFINGTON ROAD</b>   |  | 10f. Zip Code<br><b>21209</b>   |                                 | 10g. Citizen of What Country?<br><b>USA</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |                                 |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>5+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SOCIAL WORKER</b>                 |                                 | 16b. Kind of Business/Industry<br><b>NURSING HOME</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>SAMUEL RESNICK</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES UNKNOWN</b>   |                                 |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. SANDRA CRUTE (DAUGHTER)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>819 NOTTINGHAM ROAD CATONSVILLE, MD 21229</b> |                                 |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>   |                                 | 20c. Location - City or Town, State<br><b>3-25-1997 REISTERSTOWN, MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>Jay Alan Lewis</i>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>                         |                                 |   |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Lung Cancer, Mixed Squamous and</i><br>Due to (or as a consequence of):<br><i>Colon Cancer</i><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |                                 | Approximate Interval Between Onset and Death<br><i>6 months</i>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Bone Metastasis</i>   |  |   |                                 | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b> | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how Injury occurred   |                                 |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                 |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |                                 |   |
| State<br>Registrar                                      | 29b. Signature and title of certifier<br><i>Blaine M. Calkins MD</i>   |  | 29c. License number<br><b>RES 000</b>   |                                 | 29d. Date signed (Month, Day, Year)<br><b>March 22, 1997</b>  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>BEVERLY M. Calkins MD, 600 North Wolfe Street, Baltimore, Maryland 21287</b>  |  |   |                                 |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b> |  |  |   |                                 |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09230

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bernice Cohen

2. Date of Death

Month March Day 24 Year 1997

3. Time of Death

05:30AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney, Maryland

4c. County of Death

Montgomery County

5. Social Security Number

169-16-4272

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MARCH 21, 1919

9. Birthplace (State or Foreign Country)

ROMANIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ASHTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17513 SIR GALLAHAD WAY

10f. Zip Code

20861

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give X Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BENJAMIN

RAUCHBACH

ESTHER

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MARLENE ADDRESS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

341 WINDSOR PARK LANE HAVERTOWN, PA 19083

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ROOSEVELT MEMORIAL PARK 3/25/97 TREVOSE, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN RD; PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Edema

Approximate Interval Between Onset and Death

12 hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
Acute Myocardial Infarction

12-24 hours

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:

Cardiogenic Shock, Acute renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

35261

29d. Date signed (Month, Day, Year)

March 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Yackee MD 3801 International Drive #210 Silver Spring, Maryland

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

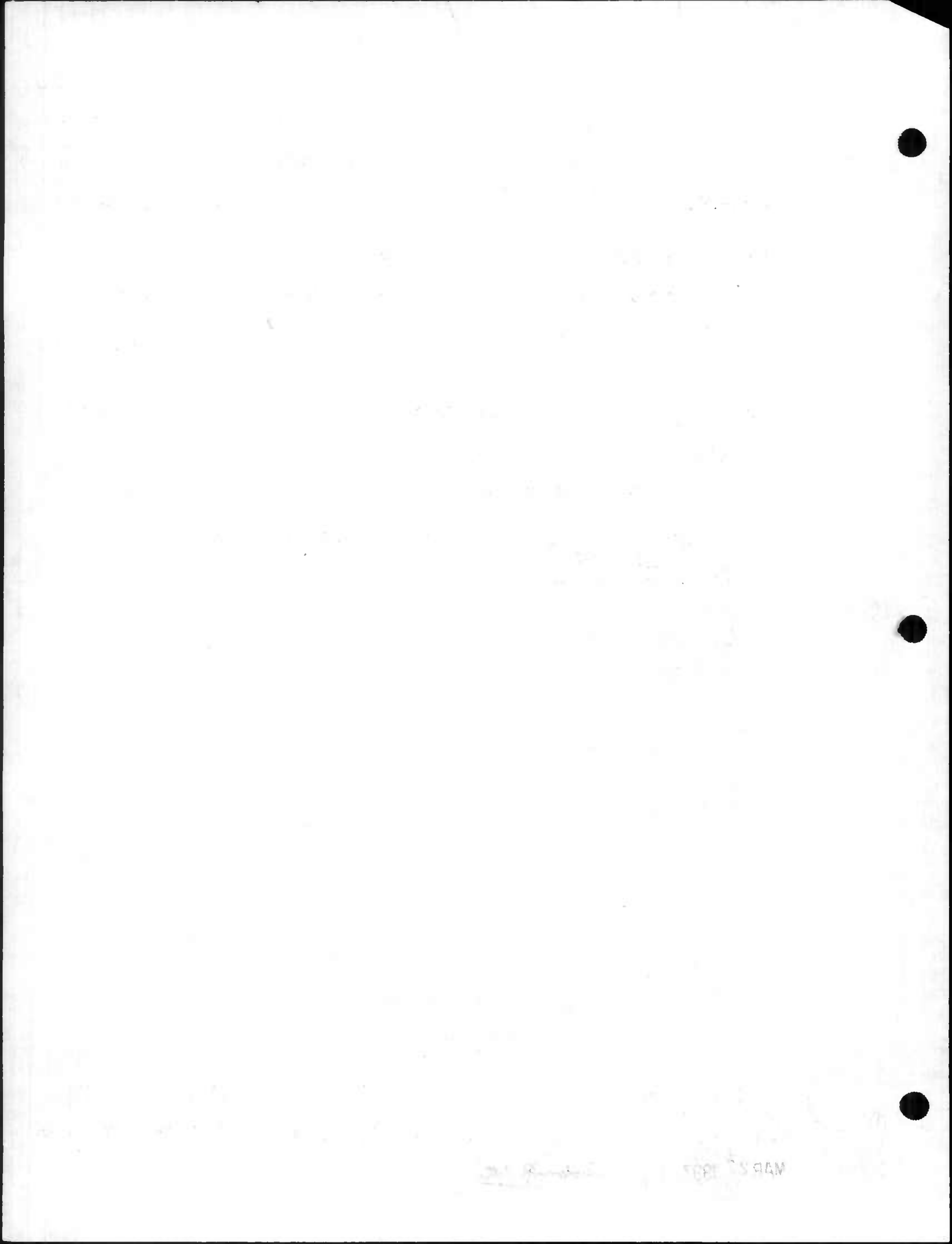
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



APR 25 1941

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State of Maryland / Department of Health and Mental Hygiene

97 09231

Item 23a, part II Per MEO Film G746 4-2997 rja

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |   |  |
|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Nicholas D. Carlo</u>                          |   |  |   | 2. Date of Death<br>Month <u>February</u> Day <u>11</u> Year <u>1997</u> |  | 3. Time of Death<br><u>11:54 AM</u>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Mercy Medical Center</u> |   |  |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>                 |  | 4c. County of Death<br><u>N/A</u>                                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>220-20-5495</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>69</u> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><u>Jan. 31, 1928</u>          | 9. Birthplace (State or Foreign Country)   |
|  | Usual Residence of Decedent   |   |  |   |  |  |   |  |
| 10a. State<br><u>Maryland</u>  |   | 10b. County   |  | 10c. City, Town or Location<br><u>Baltimore</u>   |  |  |   |  |
| 10e. Street and Number<br><u>1505 Covington Street</u>   |   |   |  | 10f. Zip Code<br><u>21230</u>   |  | 10g. Citizen of What Country?<br><u>unknown</u>                                  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>white</u> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>unknown</u> College (1-4 or 5+) <u>unknown</u>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>unknown</u>   |  |  | 16b. Kind of Business/Industry<br><u>unknown</u>                        |  |
| 17. Father's Name (First, Middle, Last)<br><u>unknown</u>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>unknown</u>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>unknown</u>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>unknown</u>   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <u>in-state</u>  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State  |   |  |
| 21. Signature of Funeral Service Licensee<br><u>Joseph B. Van Sant</u>   |   |   |  | 22. Name and Address of Facility<br><u>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</u>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>LEFT HIP FRACTURE WITH COMPLICATIONS<br>a. <u>Pulmonary hemorrhage</u><br>Due to (or as a consequence of):<br>b. <u>pneumonia</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |   | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>ATRIAL FIBRILLATION</u><br><u>Fractured hip</u><br><u>Atrial fibrillation</u>   |   |   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><u>M</u>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><u>G. Lynch MD</u>  |   |   |  | 29c. License number<br><u>D 42196</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>February 11, 1997</u>                  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>301 St. Paul Place # 907 Baltimore, MD 21202</u>  |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>MAR 27 1997</u>  |   |   |  | Registrar's Signature<br><u>John Davidson-Randall</u>   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09232

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Simon M Eggleston

2. Date of Death

Month Day Year  
MARCH 24, 1997

3. Time of Death

6:21pm

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

231-07-5361

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month, Day, Year

MAY 9, 1921

9. Birthplace (State or Foreign Country)

W. VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

1302 E. 33 RD ST

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2X Married  
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1X Yes 2□ No 1942-45  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 3X No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

BUSINESS OWNER

16b. Kind of Business/Industry

LIQUOR STORE

17. Father's Name (First, Middle, Last)

SIMON EGGELESTON SR

18. Mother's Name (First, Middle, Maiden Surname)

MARY JANE GRAVELY

19a. Informant's Name/Relationship (Type, Print)

JEAN EGGELESTON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1302 E 33RD ST BALTO, MD 21218

20a. Method of Disposition

XX Burial 2□ Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GRAVELY FAMILY CEM

Date

MAR 29  
97

20c. Location - City or Town, State

LEATHERWOOD, VA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

BETTS FUNERAL HOME  
1129 N CAROLINE ST BALTO, MD 21213 VA,  
STANDFIEL & MILLER FUNERAL HOME, MARTINSVILLE23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Aortic Dissection

Due to (or as a consequence of):

27 days

c. Hypertension

Due to (or as a consequence of):

10 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Black Lung Disease

Aortic Regurgitation

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4X Unknown

24a. Was an autopsy  
performed?

1□ Yes 2X No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1□ Yes 2□ No

25. Was case referred to medical  
examiner?

1□ Yes 2X No

26. Place of Death (Check only one)

Hospital:

1X Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1X Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending  
investigation6□ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

AT2438946-C41

29d. Date signed (Month, Day, Year)

March 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVE S FABER, 201 E. University Parkway Baltimore MD 21218

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

[Signature]

State  
Registrar

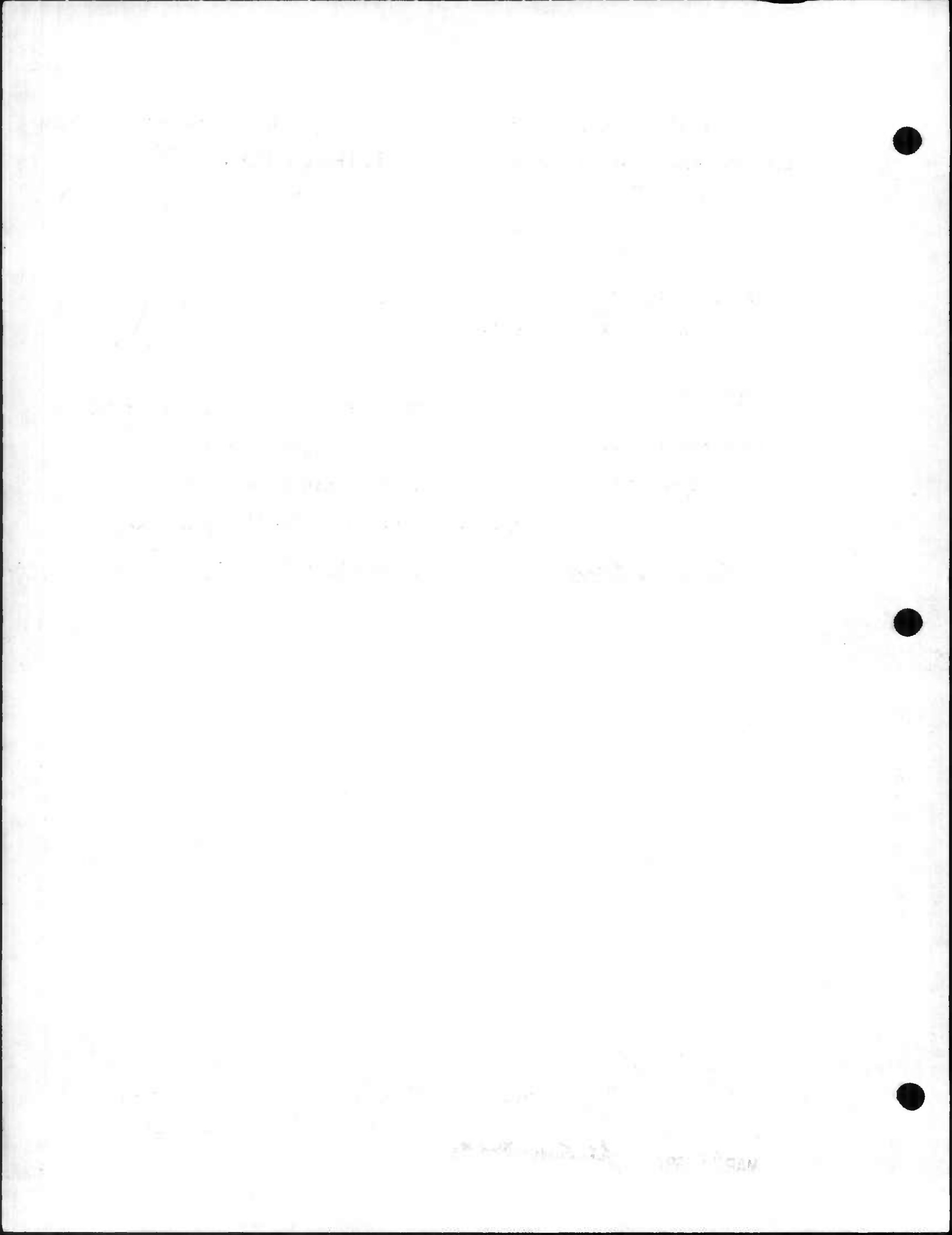
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09233

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |   |  |  |
|---|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas Ellinger</b>  |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>19</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>4:20 PM</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |   | 4c. County of Death<br><b>Prince George</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>231-16-5946</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 10, 1922</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |
|   | Usual Residence of Decedent   |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10e. State<br><b>MD</b>   | 10b. County<br><b>Howard</b>  | 10c. City, Town or Location<br><b>Laurel</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   | 10e. Street and Number<br><b>10378 Scaggsville Road</b>   |   |   | 10f. Zip Code<br><b>20723</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>0</b>  |   |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sheet Metal Mechanic</b>              |  | 16b. Kind of Business/Industry<br><b>Truck Body Repair</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Madison Ellinger</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Alice Patterson</b>  |  |   |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Shirley A. Castillo/Daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10620 Graeloach Road, Laurel, Maryland 20723</b> |  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Emmanuel UM Church Cem.</b>  |  | Date<br><b>3/22</b>  | 20c. Location - City or Town, State<br><b>Scaggsville, MD</b>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road, Laurel, Maryland 20707</b>                               |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Septicemia</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia + Sepsis</b><br>Due to (or as a consequence of):<br>c. <b>Dehydration from Rheumatoid Arthritis</b><br>Due to (or as a consequence of):<br>d. <b>Alzheimer's type Dementia</b> |   |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |   |   |   |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28e. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |   |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D13671</b>   | 29d. Date signed (Month, Day, Year)<br><b>3-19-97</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>B.G. Manejwala, M.D. 14201 Laurel Park Dr. Laurel, MD 20707</b>  |   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>   |   | 32. Registrar's Signature<br>   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director






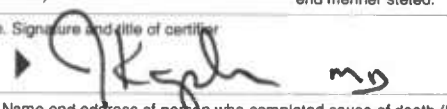
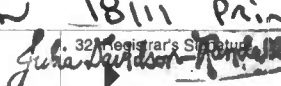
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09234

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |  |
|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MALA ENOCH</b>                                     |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 23, 1997</b> |  | 3. Time of Death<br><b>4:00 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>14616 COUNTRY CREEK LANE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>N. POTOMAC</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>062-46-7650</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 22, 1912</b>  | 9. Birthplace (State or Foreign Country)<br><b>POLAND</b>  |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10e. State<br><b>MD</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2901 TERRY DRIVE APT. E</b>   |   |   |  | 10f. Zip Code<br><b>21209</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MOZES LEV</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HENIE HERSHORN</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DR. MICHAEL ENOCH / SON</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6948 COPPERBEND LANE BALTIMORE, MD 21209</b>   |   |  |  |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH TFILOH</b>  |  | Date<br><b>3/24/97</b>   |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                          |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. NON SMALL CELL LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>5 months</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |   |   |  |  |   |  |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |   |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28e. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br><b>D 35635</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1997</b>                         |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Josiah Kaplan 1811 Prince Philip Drive, OUNY, MD 20832</b>  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |   | 32. Registrar's Signature<br>  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09235

Reg. No.

|  |  |   |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|--|--|---|---|--------------------------------------|--|--|---|--|--|--|---|---------------------------------|--|--|------------------------------------|---------------|-------------------------|---------------|-----------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RUTH E. FOWLKES</b>   |   |   |                                      |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 24 1997</b>  |  | 3. Time of Death<br><b>2:10 PM</b>   |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Liberty Medical Center</b>  |   |   |                                      |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>NA</b>   |  |   |                                 |  |  |                                    |               |                         |               |                       |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-32-6396</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>4-17-1914</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Va</b>  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | Usual Residence of Decedent  |   |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>NA</b>  |                                      | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 10e. Street and Number<br><b>3321 Dolfield Avenue</b>  |   |   |                                      | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>NA</b>  |   |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Linien Clerk</b>   |  |   | 16b. Kind of Business/Industry<br><b>Hospital</b>  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 17. Father's Name (First, Middle, Last)<br><b>Eddie Booker</b>   |   |   |                                      |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helia Doswell</b>   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Walter E. Fowlkes - Son</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>905 Windmill Lane Silver Spring, Md 20905</b>  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>  |                                      | 20c. Date<br><b>3-29-97</b>  |  | 20d. Location - City or Town, State<br><b>Arbutus, Md</b>   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 21. Signature of Funeral Service Licensee<br><b>John B. Johnson</b>  |   |   |                                      | 22. Name and Address of Facility<br><b>March F.H. West 4300 Wabash Avenue Baltimore, Md 21215</b>  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Myocardial Infarction</b></td> <td>Approximate Interval Between Onset and Death<br/><b>6 hrs</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. <b>Congestive Heart Failure</b></td> <td><b>2 days</b></td> </tr> <tr> <td>c. <b>Renal Failure</b></td> <td><b>2 days</b></td> </tr> <tr> <td>d. <b>Bradycardia</b></td> <td><b>6 hrs</b></td> </tr> </table> |   |   |                                      |  |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Myocardial Infarction</b> | Approximate Interval Between Onset and Death<br><b>6 hrs</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. <b>Congestive Heart Failure</b> | <b>2 days</b> | c. <b>Renal Failure</b> | <b>2 days</b> | d. <b>Bradycardia</b> |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Myocardial Infarction</b>  | Approximate Interval Between Onset and Death<br><b>6 hrs</b>  |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | b. <b>Congestive Heart Failure</b>   | <b>2 days</b>   |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | c. <b>Renal Failure</b>  | <b>2 days</b>   |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | d. <b>Bradycardia</b>  | <b>6 hrs</b>  |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                                      |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |                                      |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 29b. Signature and title of certifier<br><b>R. M. Shah MD</b>  |  |   |   | 29c. License number<br><b>D19608</b> |  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1997</b>  |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>R. M. SHAH MD CMC 2600 LIBERTY HWY AVE, BALTIMORE MD 21215</b>  |  |   |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Rodriguez</b>  |   |                                      |  |  |   |  |  |  |   |                                 |  |  |                                    |               |                         |               |                       |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09236

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |  |
|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Janeil Farrow</i>                        |   |  |  | 2. Date of Death<br>Month <i>March</i> Day <i>24</i> Year <i>1997</i> |  | 3. Time of Death<br><i>0015</i>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Sinai Hospital</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>              |  | 4c. County of Death<br><i>N/A</i>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>244-76-0754</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>49</i> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><i>AUG 27, 1947</i>                       |  | 9. Birthplace (State or Foreign Country)<br><i>NC</i>  |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10a. State<br><i>MD</i>   |   | 10b. County<br><i>N/A</i>   |  | 10c. City, Town or Location<br><i>BALTO</i>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><i>1280 KITMORE RD APT L</i>  |   |   |  | 10f. Zip Code<br><i>21239</i>  |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>                                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>          |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>N/A</i>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>BUS DRIVER</i>   |   | 16b. Kind of Business/Industry<br><i>MTA</i>                                     |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>CHARLIE ALLEN</i>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>LILLIE ROUNDTREE</i>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>DEVONA FARROW</i>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1280 KITMORE RD APT L BALTO, MD 21239</i>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>WOODLAWN CEM</i>   |  | Date<br><i>MAR 27 1997</i>   |   | 20c. Location - City or Town, State<br><i>WOODLAWN, MD</i>                       |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Patricia - Betts</i>  |   |   |  | 22. Name and Address of Facility<br><i>BETTS FUNERALHOME<br/>1129 N. CAROLINE ST BALTO, MD 21213</i>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |   |   |  |  |   |  |  | <i>2 days</i>  |
| a. <i>Cardiogenic Shock</i><br>Due to (or as a consequence of):   |   |   |  |  |   |  |  |  |
| b. <i>Ventricular Fibrillation</i><br>Due to (or as a consequence of):  |   |   |  |  |   |  |  | <i>10 minutes</i>  |
| c. <i>Cardiomyopathy</i><br>Due to (or as a consequence of):  |   |   |  |  |   |  |  | <i>1 yr.</i>   |
| d.  |   |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   |   |   |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |   |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Pamser m.d.</i>   |  |  |   |  |  |  |
| 29c. License number<br><i>MS2402321-008876</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>March 24, 1997</i>  |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Pearl Ramser m.d. Sinai Hospital Baltimore</i>   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 27 1997</i>   |   | 32. Registrar's Signature<br><i>Davidson-Randall</i>  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09237

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA ANNA BELLE FITZELL

2. Date of Death

Month Day Year  
MARCH 22, 1997

3. Time of Death

5:10 A.M.

4a. Facility Name (If not institution, give street and number)

MERIDIAN NURSING CENTER-HERITAGE

4b. City, Town, or Location of Death

BALTIMORE COUNTY

4c. County of Death

BALTIMORE

5. Social Security Number

220-09-2479

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 9, 1913

9. Birthplace (State or Foreign Country)

FREELAND, MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

LUTHERVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

310 IVY CHURCH ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOUSEKEEPING-OWN HOME

17. Father's Name (First, Middle, Last)

ELI DANIEL WILSON

18. Mother's Name (First, Middle, Maiden Surname)

CLARA KROUT

19a. Informant's Name/Relationship (Type, Print)

DANIEL FITZELL (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

310 IVY CHURCH ROAD LUTHERVILLE, MARYLAND 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

PINE GROVE METHODIST CHURCH MARCH 25, 1997 PARKTON, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LASSAH FUNERAL HOME, INC.  
7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part 1. Enter the disease or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CVA (CEREBROVASCULAR ACCIDENT)

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

A.S.C.V.D

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D17753

29d. Date signed (Month, Day, Year)

3-25-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

710 CHURCH ST. BALTIMORE MD 21225

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09238

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

HARRIET S. FINKEL

2. Date of Death

Month Day Year  
MARCH 17, 1997

3. Time of Death

03:10AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

182-30-5847

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 20, 1933

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedant

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4316 Van Ness St. N.W.

10f. Zip Code

20016

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedant of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedant's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedant's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Charles Schwartz

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Joseph

19a. Informant's Name/Relationship (Type, Print)

E. Jay Finkel

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as Item #10 a-f

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King David Mem. Gdns

Date

3/19/97

20c. Location - City or Town, State

Falls Church, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes  
Falls Church, Va. 2204623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 DAYS.

b. SEVERE MALNUTRITION

Due to (or as a consequence of):

1 YEAR

c. ANOREXIA NERVOSA

Due to (or as a consequence of):

20 YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERTONITIS, HYPONATREMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MARCH 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARY H. CHIANG, MD 110 TOWER, JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST. BALTIMORE MD

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09239

Reg. No.

|  |   |   |  |  |                                |  |   |
|--|---|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Alfred Benedict Gonshor</i>                |   |  | 2. Date of Death<br>Month <i>March</i> Day <i>23</i> Year <i>1997</i>  |                                | 3. Time of Death<br><i>4:00 AM</i>   |   |
|  | 4e. Facility Name (If not institution, give street and number)<br><i>1614 Leslie Road</i> |   |  | 4b. City, Town, or Location of Death<br><i>Dundalk</i>   |                                | 4c. County of Death<br><i>Baltimore</i>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>217-16-3614</i>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>73</i> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>Jan. 12, 1924</i> |
|  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>                               |   |  |  |                                |  |   |
| Usual Residence of Decedent  |   |   |  |  |                                |  |   |
| 10a. State<br><i>Maryland</i>  |   | 10b. County<br><i>Baltimore</i>   |  | 10c. City, Town or Location<br><i>Dundalk</i>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><i>1614 Leslie Road</i>  |   |   |  | 10f. Zip Code<br><i>21222</i>  |                                | 10g. Citizen of What Country?<br><i>United States</i>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>WWII</i>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8 Years</i> College (1-4or 5+) <i></i>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Mechanical Maintenance</i>   |                                | 16b. Kind of Business/Industry<br><i>Steel Industry</i>  |   |
| 17. Father's Name (First, Middle, Last)<br><i>John Gonshor</i>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Felicia Burazynski</i>   |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Irene C. Gonshor/Wife</i>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1614 Leslie Road Dundalk, Maryland 21222</i>   |                                |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Sacred Ht. of Jesus Cem.</i>   |  | Date<br><i>3/26/1997</i>   |                                | 20c. Location - City or Town, State<br><i>Dundalk, Maryland</i>                                |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  | 22. Name and Address of Facility<br><i>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</i>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>e. <i>Uremia</i></p> <p>Due to (or as a consequence of):</p> <p>b. <i>Endstage kidney failure</i></p> <p>Due to (or as a consequence of):</p> <p>c. <i>Hypertension</i></p> <p>Due to (or as a consequence of):</p> <p>d. <i>Atherosclerotic cardiovascular disease</i></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> |   |   |  |  |                                |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cerebrovascular accidents</i>   |   |   |  |  |                                |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |  |  |                                |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28d. Describe how injury occurred  |                                |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |                                |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |                                |  |   |
| 29b. Signature and title of certifier<br><i>Kevin Rossiter MD</i>  |   | 29c. License number<br><i>MD D34859</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>Mar 24 1997</i>  |                                |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Kevin Rossiter, MD Johns Hopkins Bayview Med Ctr 4940 Eastern Ave Baltimore</i>   |   |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><i>MAR 27 1997</i>  |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

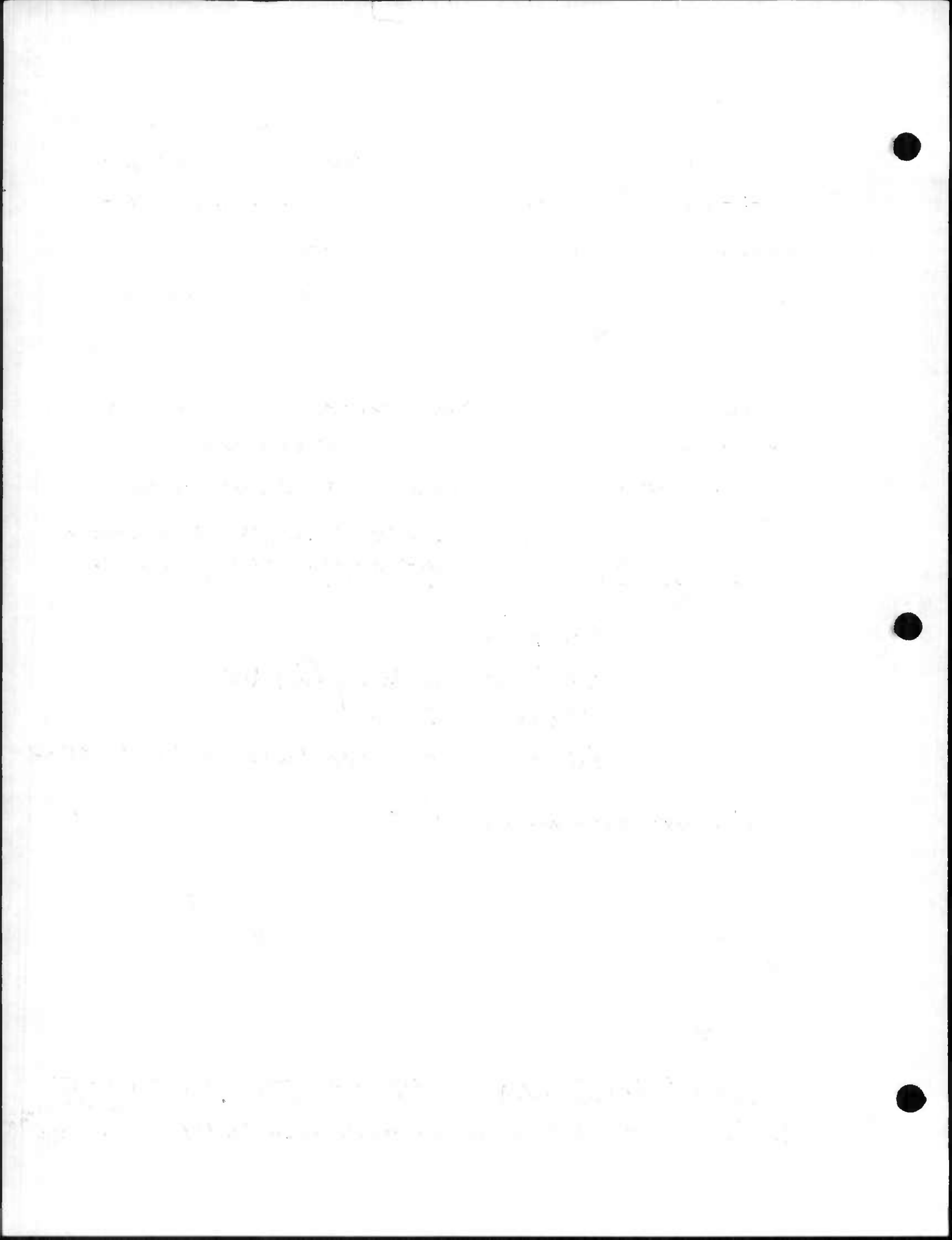
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09240

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MORTON FRANK GOETZ</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>24</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:45pm</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-07-4738</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 17, 1911</b>                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2953 MARNAT ROAD, APT. D</b>   |  | 10f. Zip Code<br><b>21209</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HABERDASHER</b>   |  | 16b. Kind of Business/Industry<br><b>CLOTHING</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>PAUL GOETZ</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HANNAH KROME</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. GOLDIE GOETZ (WIFE)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2953 MARNAT ROAD, APT. D BALTIMORE, MD 21209</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HEBREW YOUNG MENS -</b>  |  | 20c. Date<br><b>3-26-1997</b>  |  | 20d. Location - City or Town, State<br><b>BALTIMORE, MD</b>                                 |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 Reisterstown Road Pikesville, MD 21208</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Gastrointestinal Bleeding</b><br>Due to (or as a consequence of):<br><b>Thrombocytopenia</b><br>Due to (or as a consequence of):<br><b>Itcopatic Thrombocytopenia Purpura</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Insufficiency</b><br><b>Diabetes Mellitus</b><br><b>Cerebrovascular Infarctions (Multiple)</b>  |  |   |  |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |
| State Registrar  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D29606</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 24, 1997</b>                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>1838 Greene Tree Rd. Pikesville, MD 21208</b>   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |  |  |   |  |  |  |   |  |
| 32. Registrar's Signature<br>                                   |  |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

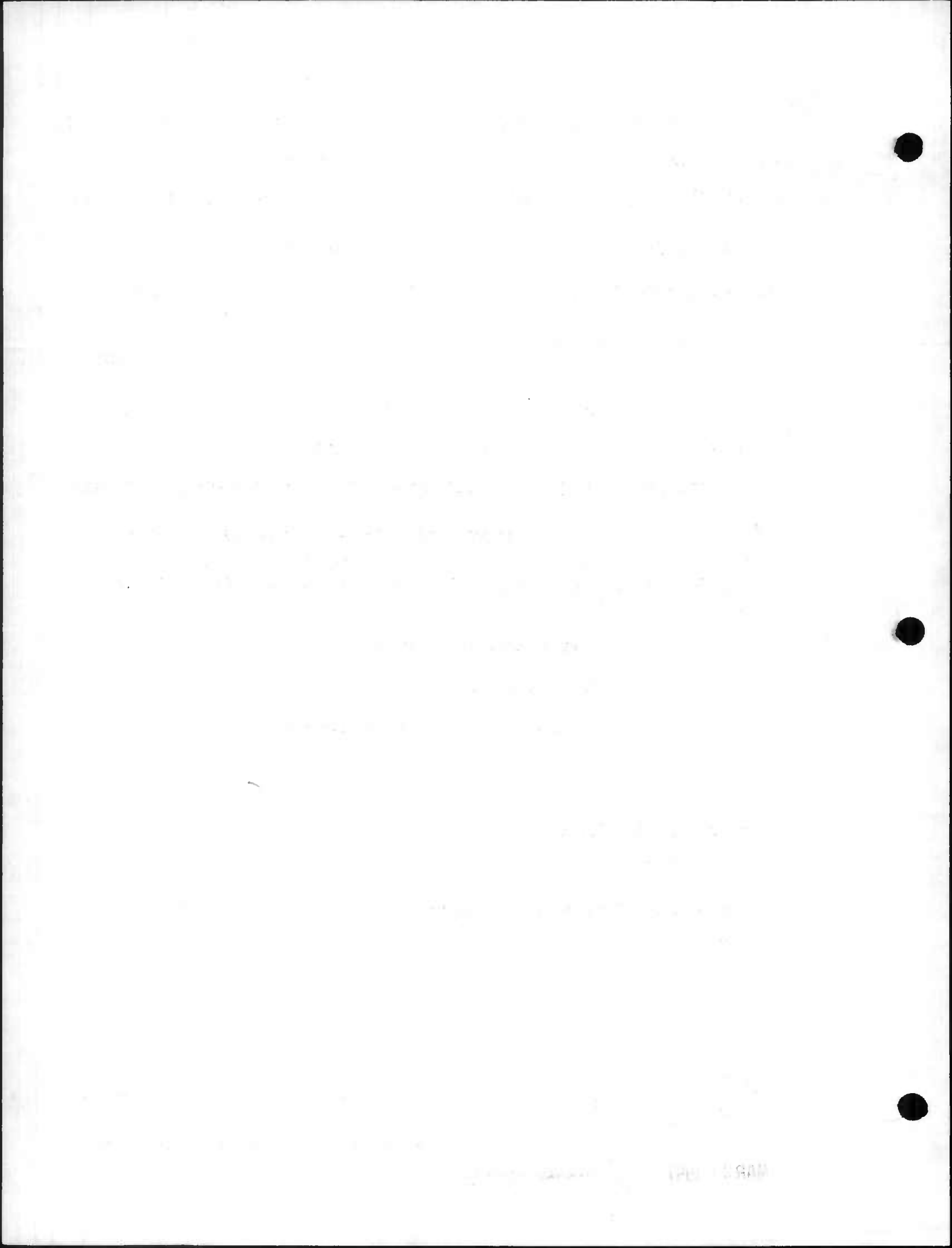
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09241  
Item 6 per FH Film G745 3-31-97 rja  
Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Thomas R. Hamlett</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>24</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>8:45 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Harbor Hospital 3001 S. Hanover St.</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>218-28-2672</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   |  |
| 8. Date of Birth<br>Month <b>4</b> Day <b>18</b> Year <b>1934</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>BALTIMORE, MD.</b>   |  |  |  |
| Usual Residence of Decedent   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  |
| 10c. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 10e. Street and Number<br><b>1106 CHERRY HILL ROAD. APT K</b>   |  | 10f. Zip Code<br><b>21225</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>51-60</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRO-AMERICAN</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAR TECHNICIAN</b>  |  |
| 16b. Kind of Business/Industry<br><b>SEAR CO.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>ROBERT JONES</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ZELMA JONES</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ALICE HAMLETT</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1106 CHERRY HILL ROAD, APT K BALTIMORE, MARYLAND 21225</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CROWNSVILLE V.A. CEM.</b>  |  | 20c. Location - City or Town, State<br><b>3/27/97 CROWNSVILLE, MD.</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MARYLAND</b>  |  |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory failure</b><br>Due to (or as a consequence of):<br><b>b. Lung Cancer</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>2 years</b>   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>Gerald Apollon MD</b>   |  | 29c. License number<br><b>D37874</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>March 24, 1997</b>  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gerald Apollon, M.D.</b>   |  | <b>Harbor Hospital 3001 S. Hanover St.</b>  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09242

ITEM#5 PER F.H. FLM#G746 4-1-97 J.a.

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |  |  |  |
|--|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frances Hamm</b>                            |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>4:30a.m.</b>  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>2112 Division St.</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |  | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-30-3868</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>9-20-33</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|  | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2112 Division St.</b>   |  |   |  | 10f. Zip Code<br><b>21217</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |  |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Social Worker</b>   |   |  | 16b. Kind of Business/Industry<br><b>Dept. of Social Serv</b>                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Vennie</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Countess</b>  |   |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Leah Hamm/daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2744 Ellicott Driveway Balto., MD 21216</b>   |   |  |  |  |
| 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>3/27</b>   |   | 20c. Location - City or Town, State<br><b>Catonsville, MD</b>                    |  |  |
| 21. Signature of Funeral Service Licensee<br><b>James A. Morton</b>  |  |   |  | 22. Name and Address of Facility<br><b>James A. Morton &amp; sons Funeral Home<br/>1701 Laurens St. Balto., MD 21217</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Adenocarcinoma</b>  |  |   |  |   |   |  |  | <b>21 months</b>   |
| Due to (or as a consequence of):   |  |   |  |   |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |   |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |   |   |  |  |  |
| Due to (or as a consequence of):   |  |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |  |   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. A. R. ...</b>  |  |   |  | 29c. License number<br><b>D40854</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 27, 97</b>                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David A. Roseberg, MD 407T 301 St. Paul Pl Baltimore, MD 21202</b>  |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09243

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |  |  |  |  |
|--|--|---|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lula M. Little</b>                              |   |  |  | 2. Date of Death<br>Month <b>3</b> Day <b>24</b> Year <b>97</b> |   | 3. Time of Death<br><b>3:30 AM</b>                     |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1619 N. Monroe Street</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>        |   | 4c. County of Death<br><b>NA</b>                       |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-30-0148</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.                |   | 8. Date of Birth (Month, Day, Year)<br><b>8-3-1899</b> |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |   | 10a. State<br><b>MA</b>  |  | 10b. County<br><b>NA</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>        |  |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1653 W. North Ave</b>   |   | 10f. Zip Code<br><b>21217</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b>  |  | College (1-4 or 5+) <b>N.A.</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC</b>   |   | 16b. Kind of Business/Industry<br><b>HOME</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MAJOR BURROWS</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE</b>  |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ELIZA BETH McCoy-Little</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1619 Monroe ST Baltimore, MA 21217</b>   |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Mem Park</b>  |  | Date<br><b>3-28-97</b>   |   | 20c. Location - City or Town, State<br><b>Randallstown, Md</b>                                  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  |   |  | 22. Name and Address of Facility<br><b>MARA F.H. WEST<br/>4300 WABASH Avenue, BALTO, MA 21215</b>  |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |   |  |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Possible ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>c. <b>ATHEROSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br>d.  |  |   |  |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>NA</b>   |  | 28b. Time of Injury<br><b>PM</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>NA</b> |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>NA</b>  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |  | 29c. License number<br><b>017148</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3-26-97</b>   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6706 HANFORD RD, BALTO, MD 21214</b>  |  |   |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09244

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERALD FRANCIS LOGAN

2. Date of Death

MARCH 18 1997

3. Time of Death

2:45 P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FALLSTON GEN. HOSP.

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

5. Social Security Number

174-12-4501

6. Sex

M 20 F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT-23, 1923 BRADDOCK, PA.

9. Birthplace (State or Country)

PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

HARFORD

10c. City, Town or Location

BELAIR

10d. Inside City Limits

1 X Yes 2 No

10e. Street and Number

205 IDLEWILD AVE 1-A

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 X Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 X Yes 2 No

4 Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CHEMICAL ENGINEER CIVIL SERVICE

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

GERALD E LOGAN SR.

18. Mother's Name (First, Middle, Maiden Surname)

LAURA REESE

19a. Informant's Name/Relationship (Type, Print)

LOUISE LOGAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 BROWN AVE. TURTLE CREEK, PA. 15445

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GOOD SHEPHERD CEM.

Date

MAR 22 1997

20c. Location - City or Town, State

MONROEVILLE, PA.

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

SKARDA F.H.

2829 HUDSON ST. BALTIMORE, MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ventricular Fibrillation

Approximate Interval Between Onset and Death

5 minutes.

Due to (or as a consequence of):

Acute Myocardial Infarction

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 X No

Hospital:

1 Inpatient 2 ER/Outpatient 3 X DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending investigation

2 Accident 6 Could not be determined

3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Kevin Lynch

29c. License number

D 35012

29d. Date signed (Month, Day, Year)

MARCH 19, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014.

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



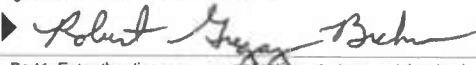

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09245

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |                                |  |  |                                   |  |
|--|---|--|--|--|--|--------------------------------|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Lawrence (AKA Laurence) D. Leyh, Jr.</b>   |  |  |  | 2. Date of Death<br>Month <b>Mar.</b> Day <b>19</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>7:35 AM</b>   |  |                                   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |                                | 4c. County of Death<br><b>Howard</b>   |  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-22-1186</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>June 15, 1926</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |                                   |  |
|  | Usual Residence of Decedent   |  |  |  |  |                                |  |  |                                   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Columbia</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                   |  |
|  | 10e. Street and Number<br><b>6305 Amherst Avenue</b>  |  |  |  | 10f. Zip Code<br><b>21046</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |                                   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>Naval Weapons Center</b>  |                                |  |  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Lawrence D. Leyh, Sr.</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Kistler</b>   |                                |  |  |                                   |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>Louise Leyh (Wife)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6305 Amherst Ave. Columbia, MD 21046</b>   |                                |  |  |                                   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>  |  | Date<br><b>March 22 1997</b>   |                                | 20c. Location - City or Town, State<br><b>Beltsville, MD</b>                                   |  |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Witzke Funeral Homes, Inc.<br/>5555 Twin Knolls Rd. Columbia, MD 21045</b>  |                                |  |  |                                   |  |
|  | 23a. Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Cardiorespiratory Failure</b><br>Due to (or as a consequence of):<br>b. <b>Pulmonary Embolism</b><br>Due to (or as a consequence of):<br>c. <b>Non-Small Cell Lung Cancer stage IV</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |                                |  | Approximate Interval Between Onset and Death<br><br><b>1 hr.</b><br><br><b>4 months</b>  |                                   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anorexia-Cachexia Syndrome</b><br><br><b>Anemia, Osteolytic bone disease.</b>  |  |  |  |  |                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |                                   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D30543</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>3-19-97</b>  |  |                                   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jon Mumford, MD 11065 Little Patuxent Parkway, Columbia MD 21044</b>   |  |  |  |  |                                |  |  |                                   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>   |  |  |  |  |                                |  |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09246

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Pat McElwee

2. Date of Death

March 25 1997 1005pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

214-18-1853

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

75

8. Date of Birth

July 29 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

6025 Falkirk Rd.

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

James

J.

DiSena

18. Mother's Name (First, Middle, Maiden Surname)

Birdie

Grammer

19a. Informant's Name/Relationship (Type, Print)

Noel McElwee-Spinnato/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3010 Temple Gate Baltimore, Md. 21209

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National Cem.

Date

3-31-97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation, Parkinson's disease

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

26. Place of Death (Check only one)

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician

20 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Usha Sunkara MD

29c. License number

AS 240-231US

29d. Date signed (Month, Day, Year)

March 25, 1997

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

Usha Sunkara MD, Sinai Hospital

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09247

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHESTER W.

Massey Sr.

2. Date of Death

Month Day Year

March 20 1997

3. Time of Death

0445

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

095-07-5177 X

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

JAN 1, 1905

9. Birthplace (State or Foreign Country)

NEWARK, MD

Usual Residence of Decedent

10a. State

N.Y.

10b. County

SUFFOLK

10c. City, Town or Location

EASTPORT

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

22 Collins CT.

10f. Zip Code

11941

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DUCK FARMER

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

PAUL R. MASSEY

18. Mother's Name (First, Middle, Maiden Surname)

CLEVER SHOCKLEY

19a. Informant's Name/Relationship (Type, Print)

INDIANA MASSEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Collins CT. EASTPORT, N.Y. 11941

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

EASTPORT CEM.

Date

MAR 24 1997

20c. Location - City or Town, State

EASTPORT, N.Y.

21. Signature of Funeral Service Licensee

Thomas J. Spada Jr.

22. Name and Address of Facility

SKARDA FH 2829 HUDSON ST  
BALTO, MD. 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Renal failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending  
investigation  
☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J A Cockey, MD

29c. License number

D25674

29d. Date signed (Month, Day, Year)

3/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J A Cockey, MD 100 Power St., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09248

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Millhouser

2. Date of Death

March 24 1997

3. Time of Death

12:31am

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

066-14-0732

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

APRIL 28, 1908

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5906 FRANKLIN AVE. #2C

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

SOCIAL SECURITY ADMIN.

17. Father's Name (First, Middle, Last)

DAVID

18. Mother's Name (First, Middle, Maiden Surname)

MILLHOUSER

ROSE

MAYER

19a. Informant's Name/Relationship (Type, Print)

FAYE P. MILLHOUSER / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5906 FRANKLIN AVE #2C BALTIMORE, MD 21207

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW FRIENDSHIP

Date

3/25/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AT24384896-B2

29d. Date signed (Month, Day, Year)

March 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 East University Parkway Baltimore, MD

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MAR 27 1981


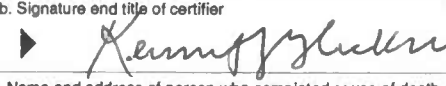
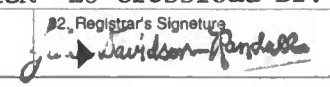
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09249

Item: 4 per Physician G-745 3/26/97 reb

Certificate of Death

Reg. No.

|   |   |  |   |                                      |   |   |   |   |  |  |
|---|---|--|---|--------------------------------------|---|---|---|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Leslie Miller, Sr.</b>  |  |   |                                      |   |   | 2. Date of Death<br>Month Day Year<br><b>March 16, 1997</b>             |   | 3. Time of Death<br><b>10:40 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>21 Pleasant Hill, Rd</b>   |  |   |                                      |   |   | 4b. City, Town, or Location of Death<br><b>Owings Mills</b>             |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>244-03-1188</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>July 22, 1905</b>             |   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b>                                 |  |
|   | Usual Residence of Decedent   |  |   |                                      |   |   |   |   |  |  |
| <b>To Be Completed by Funeral Director</b>  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore Co.</b>   |                                      | 10c. City, Town or Location<br><b>Owings Mills</b>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>21 Pleasant Hill Rd.</b>   |  |   |                                      | 10f. Zip Code<br><b>21117</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                             |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>  |   |   | 16b. Kind of Business/Industry<br><b>auto</b>                           |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ira Miller</b>  |  |   |                                      |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Woods</b> |   |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Miller, Jr./ Son</b>  |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>716 S. Main St., Bel Air, MD</b>  |   |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cem.</b>   |                                      | Date<br><b>3/20/97</b>  |   | 20c. Location - City or Town, State<br><b>Pikesville, MD</b>            |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |                                      | 22. Name and Address of Facility<br><b>11824 Reisterstown Rd.<br/>Eline Funeral Home Reisterstown, MD 21136</b>   |   |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Prostate Cancer</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |   |                                      |   |   |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                      |   |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                      |   |   |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                      |   |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>  |   |  |   |                                      |   |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                      |   |   |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |                                      |   |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>      |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br> |   | 29c. License number<br><b>D23679</b> |   | 29d. Date signed (Month, Day, Year)<br><b>03-17-97</b>                                      |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Kenneth L. Glick 20 Crossroad Dr. Owings Mills, MD 21117</b>   |   |  |   |                                      |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>   |   |  |   |                                      |   |   |   |   |  |  |
| 32. Registrar's Signature<br>  |   |  |   |                                      |   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE  
UNITED STATES  
DEPARTMENT OF AGRICULTURE

OFFICE OF THE  
SECRETARY

WASHINGTON, D. C.

1917

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09250

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Francis Neilson

2. Date of Death

March 26 1997

3. Time of Death

1:16 am

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-20-4036

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12-15-1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1010 Breezewick Road

10f. Zip Code

21286

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Beverage Dist.

17. Father's Name (First, Middle, Last)

Charles Carroll Neilson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Glasser

19a. Informant's Name/Relationship (Type, Print)

Mrs Karen S. Neilson (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1010 Breezewick Road, Towson, Md. 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Heart Of Jesus Cem.

Date

3-31-97

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road, Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)e. ANOXIC ENCEPHALOPATHY s/p SUDDEN CARDIAC DEATH  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PUCO

ALCOHOLIC CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD 32639

29d. Date signed (Month, Day, Year)

3/26/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TIMOTHY E. HELLING, M.D.

660 KENILWORTH DR. TOWSON, MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital: Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09251

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE OWENS

2. Date of Death

Month Day Year  
MARCH 23 1997

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-24-2348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
9/26/1915

9. Birthplace (State or Foreign Country)

BALTIMORE, MD.

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2718 N. CALVERT STREET

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO.AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STATE OF MARYLAND

16b. Kind of Business/Industry

CLERK

17. Father's Name (First, Middle, Last)

JAMES JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE JOHNSON

19a. Informant's Name/Relationship (Type, Print)

ROBERT L. JOHNSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4018 1/2 N. ROGERS AVE, BALTIMORE, MARYLAND 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

3/28/97

20c. Location - City or Town, State

RANDALLSTOWN, MD.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME, P.A.  
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

23a. Pert. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. ARRHYTHMIA S

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

DAYS

DAYS

HOURS

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* N. Lamprey-Mills MD

29c. License number

D44462

29d. Date signed (Month, Day, Year)

03/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. LAMPREY-MILLS, GOOD SAMARITAN HOSPITAL, BALTIMORE

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09252

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lee Pendergast

2. Date of Death

March 25, 1997

3. Time of Death

4:14 AM

4a. Facility Name (If not institution, give street and number)

1924 St. Gregory Drive

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-20-6502

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 4, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7924 St. Gregory Drive

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11 Years

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Pharmacy Assistant

16b. Kind of Business/Industry

Pharmacy

17. Father's Name (First, Middle, Last)

Earl Richard Randall

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Pearl Martin

19a. Informant's Name/Relationship (Type, Print)

Bernard W. Pendergast/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7924 St. Gregory Drive Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

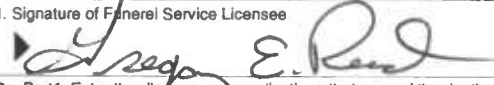
Oak Lawn Cemetery 3/28/1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Lymphoma

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D43732

29d. Date signed (Month, Day, Year)

March 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Hager, MD 5505 Hopkins Bayview Circle, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09253

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William John Panoni, Sr.

2. Date of Death

March 24, 1997

3. Time of Death

8:10 A

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-16-5119

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 22, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2065 Shore Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

Loreto Panoni

18. Mother's Name (First, Middle, Maiden Surname)

Antoinette Consalluo

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Willinger/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

722 Aldworth Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Mem. Pk. Cem. 3/27/1997

Data

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

D. E. Reed

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7222 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. acute myocardial infarction  
Due to (or as a consequence of):b. acute coronary insufficiency  
Due to (or as a consequence of):c. cardiomyopathy  
Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Naomi R. Cutler MD

29c. License number

027220

29d. Date signed (Month, Day, Year)

3/25/97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Naomi R. Cutler 1005 North Point Blvd, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

97 09254

## Certificate of Death

Reg. No.

|   |  |   |   |                                       |  |  |  |  |
|---|--|---|---|---------------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Sophia May Payne   |   |   |                                       | 2. Date of Death<br>Month Day Year<br>March 21 1997  |  | 3. Time of Death<br>10:45 AM                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Golden Oaks Nursing Home   |   |   |                                       | 4b. City, Town, or Location of Death<br>Laurel   |  | 4c. County of Death<br>Prince George                             |  |
| Funeral<br>Director   | 5. Social Security Number<br>235-42-0343   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>91 Yrs.   | If Under 1 Year<br>Months Days        | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>Nov. 23, 1905  | 9. Birthplace (State or Foreign Country)<br>Kentucky             |  |
|   | Usual Residence of Decedent  |   |   |                                       |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   | 10b. County<br>Prince George  |   | 10c. City, Town or Location<br>Laurel |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>8114 Fenwick Court   |   |   |                                       | 10f. Zip Code<br>20707   |  | 10g. Citizen of What Country?<br>United States                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                             |                                       | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Bremmer McCoy   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br>Flora Ward  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Isabelle Gibson/ Daughter  |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8114 Fenwick Court, Laurel, Maryland 20707  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Southern Memorial Gardens   |                                       | Date<br>3/24   |  | 20c. Location - City or Town, State<br>Dunkirk, Maryland         |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |                                       | 22. Name and Address of Facility<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road Laurel, Maryland 20707  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Alzheimer's Dementia</u><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |                                       |  |  |  | Approximate Interval Between Onset and Death<br>5 yrs  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Parkinson's Disease</u>   |   |   |                                       |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |                                       |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M              |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>H35116         |  | 29d. Date signed (Month, Day, Year)<br>3/22/97   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Nicholas J. Placentra Jr, DO, 11018 Lockwood Dr, Silver Spring, MD 20901  |  |   |   |                                       |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 27 1997  |  | 32. Registrar's Signature<br>   |   |                                       |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09255

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |                                     |   |  |
|---|---|--|---|---|--|-------------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Irene Poitras</i>  |  |   | 2. Date of Death<br>Month <i>March</i> Day <i>25</i> Year <i>1997</i> |  | 3. Time of Death<br><i>10:30 AM</i> |   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><i>ST. ELIZABETH NURSING HOME BALTIMORE</i>   |  |   | 4b. City, Town, or Location of Death<br><i>N/A</i>                    |  | 4c. County of Death<br><i>N/A</i>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>016-09-2198</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>88</i> Yrs.   |                                     | 8. Date of Birth (Month, Day, Year)<br><i>OCT. 23, 1908</i>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>SALEM, MA.</i>   |  | 10a. State<br><i>MD.</i>  |   | 10b. County<br><i>HOWARD</i>   |                                     | 10c. City, Town or Location<br><i>COLUMBIA</i>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><i>5272 BRIGHT DAWN CT.</i>   |   | 10f. Zip Code<br><i>21045</i>  |                                     | 10g. Citizen of What Country?<br><i>U. S. A.</i>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>HOMEMAKER</i>   |   | 16b. Kind of Business/Industry<br><i>OWN HOME</i>  |                                     | 17. Father's Name (First, Middle, Last)<br><i>AUGUSTIN TALBERT</i>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>EMMA LANDAY</i>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>MARLENE KOWALSKI</i>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5272 BRIGHT DAWN CT. COLUMBIA, MD 21045</i>  |                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>ST. MARY'S CEM.</i>  |  | 20c. Location - City or Town, State<br><i>SALEM, MA.</i>  |   | 21. Signature of Funeral Service Licensee<br><i>Thomas J. Akanda Jr.</i>   |                                     | 22. Name and Address of Facility<br><i>SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224</i>   |  |
|   | 23a. Pert I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Pulmonary Edema</i><br>Due to (or as a consequence of):<br><i>b. Congestive Heart Failure</i><br>Due to (or as a consequence of):<br><i>c. Atherosclerotic Cardiovascular Disease</i><br>Due to (or as a consequence of):<br><i>d.</i> |  | Approximate Interval Between Onset and Death<br><i>1 wk</i><br><i>1 yr</i><br><i>10 yrs</i>   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                     | 28a. Date of Injury (Month, Day, Year)  |  |
|   | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |                                     | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| State Registrar   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>William Russell</i>   |   | 29c. License number<br><i>D30182</i>   |                                     | 29d. Date signed (Month, Day, Year)<br><i>MARCH 26, 1997</i>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>WILLIAM RUSSELL MD 3421 BENSON AVE BALT. MD 21227</i>  |  | 31. Date filed (Month, Day, Year)   |   | 32. Registrar's Signature<br><i>▶</i>  |                                     |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09256

Items: 23 part I, 27, 28a-f per MEO G-746 4/1/97

Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |  |
|--|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>IVAN RAHEEM</b>   |   |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>20</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:10 PM.</b>   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>CHURCH HOSPITAL</b>   |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-74-7951</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 1, 1959 Maryland</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>771 GEORGE STREET</b>   |   |   | 10f. Zip Code<br><b>21201</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 years</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>                       |  | 16b. Kind of Business/Industry<br><b>PRIVATE BUSINESS</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>HAMID ABDUR RAHEEM</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>TISHA BENNETT</b>  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARSHIELA McDOWELL / Sister</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3948 OAKHILL AVE BALTIMORE, MD 21215</b> |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>VUSHEH MEMORIAL GARDEN</b>   |  | Date<br><b>3/27/97</b>   | 20c. Location - City or Town, State<br><b>DUNDALK, Maryland</b>                             |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Quay Harris</b>  |   |   | 22. Name and Address of Facility<br><b>CHATHAM - HARRIS A. H. 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215</b>                           |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>NARCOTIC INTOXICATION</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |   |  |  |   |  | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>found 3/20/97</b>  |   | 28b. Time of Injury<br><b>found 7:20 M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b>   |  | 28d. Describe how injury occurred<br><b>Unknown</b>   |   |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>241 Silver Court Baltimore, Md.</b>   |  |   |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Monique Dorell</b>  |   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 21, 1997</b>                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARYLAND A. KOSOW MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 24 1997</b>  |  | 32. Registrar's Signature<br><b>John Hamilton-Rodell</b>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items 20a-20c 3-27-97 Film G745 W.H. Per F/H

## Certificate of Death

Reg. No.

97 09257

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Rebmann

2. Date of Death

Month Day Year  
March 23 1997

3. Time of Death

1505

4a. Facility Name (If not institution, give street and number)

Deaton Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-32-0218

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 21, 1906

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5509 Willys Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

cleaning person

16b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

Ernest Rebmann

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Shirley Smith, guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

143 Main Street Westminster, MD 21133

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of)

Metro Crematory  
~~Louisa Park Cemetery~~

Date

3/26

20c. Location - City or Town, State

Catonsville, Maryland  
~~Baltimore, Maryland~~

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc. Arbutus  
1328 Sulphur Spring Road 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e.

Septicemia

2 weeks

Due to (or as a consequence of):

b.

Cellulitis And Pneumonia

2 weeks

Due to (or as a consequence of):

c.

Urinary Tract infection

3 weeks

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multi-infarct Dementia: Insulin Dependent

Diabetes Mellitus: Hematemesis.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01346

29d. Date signed (Month, Day, Year)

03 (March) 24: 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES P. G. FLYNN MD DEATON SPECIALTY HOSPITAL 611 S. Charles St 21230

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09258

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA NAOMI ROSE

2. Date of Death

Month Day Year  
MARCH 23 97

3. Time of Death

1100 AM

4a. Facility Name (If not institution, give street and number)

DEATON MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-20-6480

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUG. 01 1913

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1041 W. FAYETTE STREET

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

PHILLIP GREEN

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH GREEN

19a. Informant's Name/Relationship (Type, Print)

Rosalind E. Leak/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1041 W. Fayette St., Baltimore, Maryland 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

3-29

20c. Location - City or Town, State

Brooklyn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H

1206 W. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immed.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial fibrillation, chronic

Due to (or as a consequence of):

? years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-06204

29d. Date signed (Month, Day, Year)

Mar. 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

611 S. Charles St., Balt., MD 21230

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09259

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |
|---|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EMAN STEWART</b>   |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>14</b> , Year <b>1997</b>  |   | 3. Time of Death<br><b>8:55 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>N/A</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>0</b> Yrs.  | If Under 1 Year<br>Months <b>1</b> Days <b>0</b>  | If Under 24 Hrs.<br>Hours <b>2</b> Min. <b>14</b>  | 8. Date of Birth (Month, Day, Year)<br><b>2-14-1997</b>  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   |  |   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |  |   |  |  |
|   | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTO. CO.</b>  | 10c. City, Town or Location<br><b>Baltimore CO.</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>7407 LEXHAM COURT</b>  |   |  | 10f. Zip Code<br><b>21244</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFR. AMERICAN</b>   |   |  |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+) <b>0</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>                            |   | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>CHARLES McBEAN</b>  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SYREETA STEWART</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>SYREETA STEWART (MOTHER)</b>   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7407 LEXHAM CT. BALTO. MD 21244</b> |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KINGS MEM. PARK</b>   |   | Date<br><b>3/22/97</b>   | 20c. Location - City or Town, State<br><b>RANDALLSTOWN MD</b>                                  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME P.A.<br/>1300 EUTAW PLACE BALTIMORE MD 21217</b>                                |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>SEPSIS</b><br/>Due to (or as a consequence of):</p> <p>b. <b>NECROTIZING ENTEROCOCITIS</b><br/>Due to (or as a consequence of):</p> <p>c. <b>PREMATURITY</b><br/>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> |   |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>M</b>   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D30206</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/16/97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STEVEN H. PEARSON</b>  |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>   |   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



J.A. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM#19 PER F.H. FLM#G746 4/19/97 State of Maryland / Department of Health and Mental Hygiene  
Item# 3-27-97 FilmG745 W.H.Per Doctor  
ITEM#3 PER DOCTOR FLM#G746 4/4/97 J.A. Certificate of Death

97 09260

Reg. No.

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Anna Marie <del>Swartzman</del> Schwartzman</b>   |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>23</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>9:15 AM</b><br><b>3:30 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4817 Carmella Drive</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-56-3399</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>march 23, 1949</b>  |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>4817 Carmella Drive</b>  |  | 10f. Zip Code<br><b>21227</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4or 5+)</b><br><b>+2</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>legal assistant</b>                |  | 16b. Kind of Business/Industry<br><b>hospital</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William H. Tyler</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Louise Dutterer</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Stanley E. <del>Swartzman</del> SCHWARTZMAN</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>husband 4817 Carmella Drive Baltimore, MD 21227</b>   |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>3/27/97 Woodlawn, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br><b>Ambrose Funeral Home, Inc.</b><br><b>1328 Sulphur Spring Road</b><br><b>Arbutus 21227</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>OVARIAN Cancer</b> |  | Approximate Interval Between Onset and Death<br><b>20 months</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| Division of Vital Records, P.O. Box 68760,    | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D46515</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24<sup>th</sup> 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Leanne O'Neil</b><br><b>Jones Hopkins Oncology Center Baltimore MD 21287</b>   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |  | 32. Registrar's Signature<br>   |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09261

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Erika Schroeder

2. Date of Death

Month Day Year  
MARCH 25 1997

3. Time of Death

3:10 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONT. CO.

5. Social Security Number

220-80-5864

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
SEPT. 19, 1942

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State  
MD.

10b. County

P. G. CO.

10c. City, Town or Location

BELTSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3584 POWDER MILL RD.

10f. Zip Code

20705

10g. Citizen of What Country?

GERMANY

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

KARL POHLMANN

18. Mother's Name (First, Middle, Maiden Surname)

ANNA GRUBER

19a. Informant's Name/Relationship (Type, Print)

MICHAEL SCHROEDER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3691 RODGERS AVE. ELLICOTT CITY, MD. 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

MAR 24 1997

20c. Location - City or Town, State

BALTO. CO. MD

21. Signature of Funeral Service Licensee

Phonon J. Skarda Jr.

22. Name and Address of Facility

SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Ischemic / Infarcted Bowel

10 wks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic cardiovascular disease

10 wks

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver failure

Short bowel syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.

29b. Signature and title of certifier

Frank Skarda

29c. License number

143199

29d. Date signed (Month, Day, Year)

March 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

10301 Georgia Avenue #205 Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09262

ITEM:20a G-745 3-25-97 eoh

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Sidney Schuster

2. Date of Death

March

Day

Year

24 1997

3. Time of Death

1555

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

5. Social Security Number

107-16-6064

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

SEPT. 5, 1920

9. Birthplace (State or Foreign

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7203 ROCKLAND HILLS DR., APT. 301

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

BAKERY PRODUCTS

17. Father's Name (First, Middle, Last)

BENNY

SCHUSTER

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIE

TROPP

19a. Informant's Name/Relationship (Type, Print)

ELLEY SCHUSTER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 CORNBURY CT. OWINGS MILLS, MD 21117

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SWINICHER WOLINER BENEF. SOC. 3/26/1997 BALTO., MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e. pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure, hypothyroidism, coronary  
artery disease, cerebrovascular accident,  
intracerebral bleed

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elie G. Cohen, MD

29c. License number

AS-2402321-EC9008 March 24, 1997

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 W. Belvedere Ave Baltimore, MD 21215

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97 09263

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09264

## Certificate of Death

Reg. No.

|                                     |   |  |   |  |  |  |  |  |   |  |
|-------------------------------------|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>CECELIA SANTOS</u>   |  |   |  | 2. Date of Death<br>Month <u>March</u> Day <u>24</u> Year <u>1997</u>  |  |  |  | 3. Time of Death<br><u>7:45 PM</u>  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><u>CHURCH HOME HOSPITAL</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>BALTIMORE CITY</u>  |  |  |  | 4c. County of Death<br><u>N/A</u>   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><u>218-28-3595</u>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>88</u> Yrs.   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  |
|                                     | 8. Date of Birth (Month, Day, Year)<br><u>NOV. 9, 1908</u>  |  | 9. Birthplace (State or Foreign Country)<br><u>SOUTH CAROLINA</u>   |  | 10a. State<br><u>MARYLAND</u>  |  | 10b. County<br><u>N/A</u>  |  | 10c. City, Town or Location<br><u>BALTIMORE CITY</u>  |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><u>1713 N. PATTERSON PARK AVE.</u>  |  | 10f. Zip Code<br><u>21213</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>                                   |  |   |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>NEGROE</u>         |  |   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>3RD</u><br>College (1-4 or 5+) <u>N/A</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>HOUSEWIFE</u>   |  | 16b. Kind of Business/Industry<br><u>HOME</u>  |  |  |  |   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><u>JAMES WRIGHT</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>MARY</u>   |  |  |  |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><u>SHARON WEEMS- DAUGHTER</u>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2608 CECIL AVE. BALTO, MD. 21218</u>   |  |  |  |   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>BALTIMORE CEM.</u>   |  | Date<br><u>MARCH 29, 1997</u>  |  | 20c. Location - City or Town, State<br><u>BALTIMORE, MD.</u>                     |  |   |  |
|                                     | 21. Signature of Funeral Service Licensee<br><u>Calvin B. Scruggs, Jr.</u>  |  | 22. Name and Address of Facility<br><u>CALVIN B. SCRUGGS FUNERAL HOME</u><br><u>1412 E. PRESTON ST. BALTO, MD. 21213</u>  |  |  |  |  |  |   |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <u>RENAL FAILURE</u><br>Due to (or as a consequence of):<br>b. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><u>YEARS</u><br><u>YEARS</u>                          |  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br><u>ARTERIOSCLEROTIC HEART DISEASE</u><br><u>CONGESTIVE HEART FAILURE</u>  |  |   |  |  |  |  |  |   |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>D15135</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>MARCH 24, 1997</u>                     |  |   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>DEMEUNE P. SCOTT MD Church Home Hospital</u>   |  |   |  |  |  |  |  |   |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><u>MAR 27 1997</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09265

Item 23 Part I, II Per MEO FilmG746 4-8-97 rja Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT THOMPSON</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>24</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:20 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MARYLAND GENERAL HOSPITAL E.R.</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>014-86-9479</b>  |  | 6. Sex<br><b>1 M 2 F</b>  |  | 7. Age (In yrs. last birthday)<br>Yrs. _____   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 20, 1970</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  | 10e. Street and Number<br><b>1726 Division Street</b>   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><b>1 Navar Marriad 2 Married 3 Widowed 4 Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b>  |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>10th grade</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>   |  | 16b. Kind of Business/Industry<br><b>Private Business</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>SIDNEY THOMPSON</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSLYN POPE</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSLYN POPE / Mother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1726 Division Street BALTIMORE, MD 21217</b> |  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>      |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>VOSHILL MEMORIAL GARDENS</b>  |  | 20c. Location - City or Town, State<br><b>411/97 DUNDALK, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  | 22. Name and Address of Facility<br><b>CHAYAM - HARRIS P.H. 5248 REISTERSTOWN ROAD BALTIMORE, Maryland 21211</b> |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>                 |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><b>XX Yes 2 No</b>   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>   |  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>                        |  | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No</b>           |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>28b. Location (Street and Number or Rural Route Number, City or Town, State)</b>  |  | 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>O.C.M.E</b>  |  |
| State Registrar                               | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09266

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellen E Van Riper

2. Date of Death

March 25 1997

3. Time of Death

6:04 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

215-09-7452

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 21, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3018 Autumn Branch Lane

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Banker

16b. Kind of Business/Industry

Bank

17. Father's Name (First, Middle, Last)

Charles A. Copperthite

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Norwood

19a. Informant's Name/Relationship (Type, Print)

Sue Davis (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20109 Lake Park Drive Lynwood, Illinois 60411

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory, Inc

Date

March 28, 1997

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Robert H. Hays

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.

1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 mos

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bernard P. Farrell MD

29c. License number

D18317

29d. Date signed (Month, Day, Year)

Mar. 25 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bernard P. Farrell MD 11055 Little Patuxent Pkwy, Columbia, MD 21044

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital/Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.  
Items: 5,8,11,16a,b,17,18,20a,b,c per F.H. G-747 5/23/97 r9b  
State of Maryland / Department of Health and Mental Hygiene  
ITEM#24a PER PHYS. FLM#G745 3/27/97 J.A.  
Certificate of Death

97 09267

Reg. No.

|   |   |  |  |  |  |  |  |  |   |  |                                      |  |   |   |  |  |  |   |  |   |  |   |  |  |  |
|---|---|--|--|--|--|--|--|--|---|--|--------------------------------------|--|---|---|--|--|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Melvin L. Westman</i>  |  |  |  | 2. Date of Death<br>Month <i>03</i> Day <i>20</i> Year <i>1997</i> |  |  |  | 3. Time of Death<br><i>1:40 PM</i>                          |  |                                      |  |   |   |  |  |  |   |  |   |  |   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Home Health of Southern Maryland Clinton, Maryland</i> |  |  |  | 4b. City, Town, or Location of Death<br><i>Clinton, Maryland</i>   |  |  |  | 4c. County of Death<br><i>Prince George's County</i>        |  |                                      |  |   |   |  |  |  |   |  |   |  |   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>216-38-8800</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><i>55</i> Yrs.                   |  | 8. Date of Birth<br>Month <i>04</i> Day <i>18</i> Year <i>1941</i> |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |  |                                      |  |   |   |  |  |  |   |  |   |  |   |  |  |  |
|   | 10a. State<br><i>Maryland</i>   |  |  |  |  |  |  |  |   |  | 10b. County<br><i>Prince Georges</i> |  | 10c. City, Town or Location<br><i>Clinton</i> |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |   |  |   |  |  |  |
| 11. Marital Status <i>unknown</i><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>0</i>  |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>unknown</i> <i>HOMMAKER/ NURSES AIDE</i>  |  |  |  | 16b. Kind of Business/Industry<br><i>unknown</i> <i>PRIVATE</i>   |  |   |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>unknown</i> <i>PERCY ROSS</i>   |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>unknown</i> <i>MARY WILSON</i>  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Phyllis Dickerson/daughter</i>   |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4403 Sharon Drive, Pasadena, Maryland 21122</i>   |  |  |  |   |  |   |  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>LEE'S CREMATORY</i>  |  |  |  | Date<br><i>3/27/97</i>  |  | 20c. Location - City or Town, State<br><i>CLINTON, MARYLAND</i>                             |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Joseph B. Van Sant</i>  |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 22. Name and Address of Facility<br><i>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</i>   |  |  |  |   |  |   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>End Stage H.I.V.</i><br>Due to (or as a consequence of):  |   |  |  |  |  |  |  |  |   |  |                                      |  |   | Approximate Interval Between Onset and Death<br><i>1 yr.</i>  |  |  |  |   |  |   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |  |  |  |  |   |  |                                      |  |   |   |  |  |  |   |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 28a. Date of Injury (Month, Day Year)   |  |  |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred                                       |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 29b. Signature and title of certifier<br><i>LAKMIA BERWA</i>  |  |  |  | 29c. License number<br><i>24534</i>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><i>3/28/97</i>                   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>LAKMIA BERWA, 7700 Old Branch Ave</i>  |   |  |  |  |  |  |  |  |   |  |                                      |  |   |   |  |  |  |   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 27 1997</i>   |   |  |  |  |  |  |  |  |   |  |                                      |  |   | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |  |  |  |   |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09268

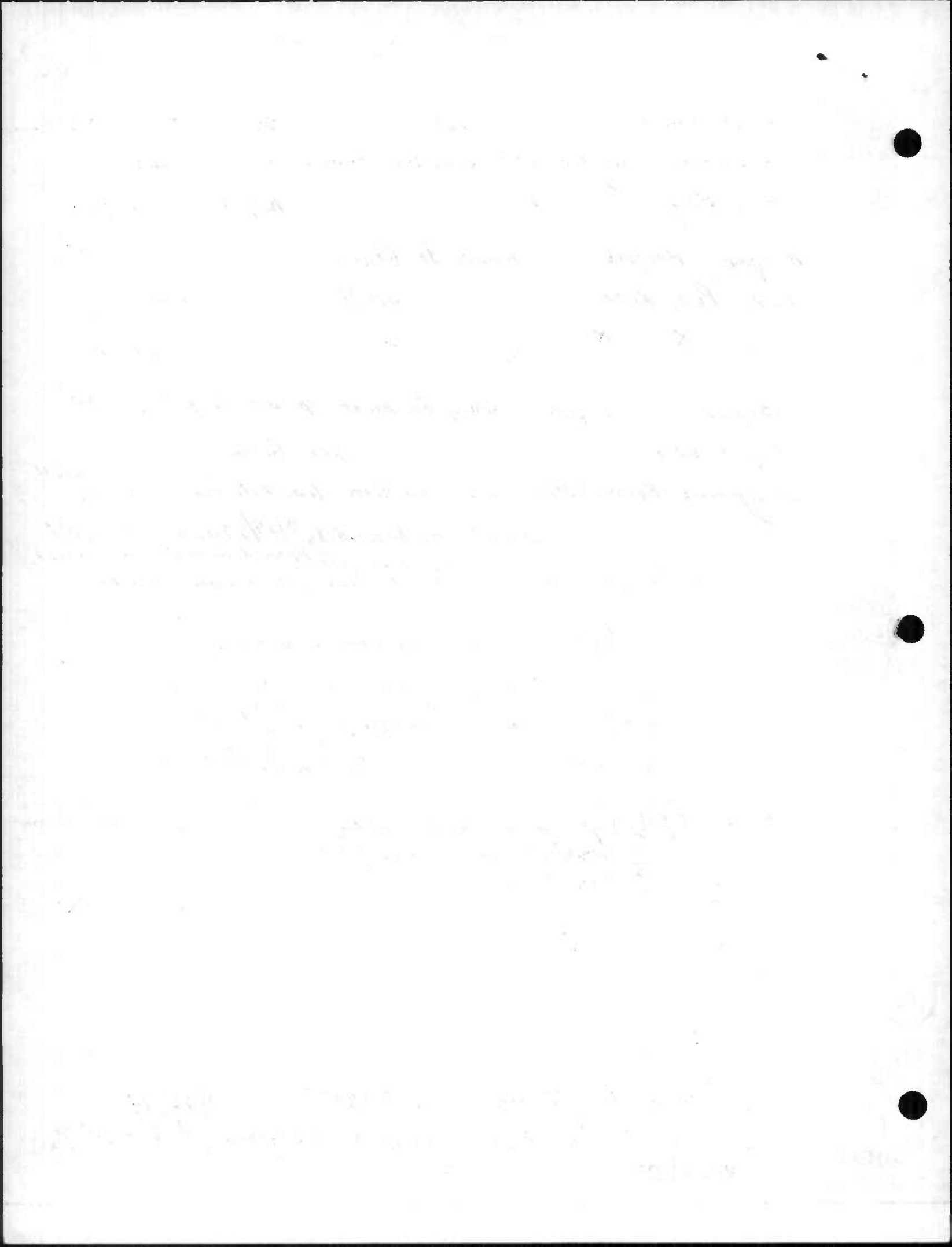
## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Booker Washington Welsh   |  |  |  | 2. Date of Death<br>Month: March, Day: 24, Year: 1997  |  | 3. Time of Death<br>7:30 p.m.                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Harford Memorial Hospital 501 S. Union Ave.   |  |  |  | 4b. City, Town, or Location of Death<br>Havre de Grace   |  | 4c. County of Death<br>Harford                                   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>24-01-7991   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>80 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Aug. 18, 1916             |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland   |  | 10b. County<br>Harford   |  | 10c. City, Town or Location<br>Havre de Grace                    |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>2321 Post Road   |  | 10f. Zip Code<br>21078   |  | 10g. Citizen of What Country?<br>USA                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 years  |  | 16. Kind of Business/Industry<br>College (1-4 or 5+)<br>1 year   |  | 17a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Heavy Equipment Operator  |  | 17b. Kind of Business/Industry<br>Self Employed                  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Robert Welsh   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mac Brown   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Josephine Gordon Welsh  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2321 Post Road Havre de Grace, Maryland 21078   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Union United Methodist Ch.   |  | 20c. Location - City or Town, State<br>3/29/97 Havre de Grace, Md  |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Arnold Beard   |  |  |  | 22. Name and Address of Facility<br>Arnold Beard Funeral Home<br>552 Lewis Street<br>Havre de Grace, Maryland 21078  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cardiac - pulmonary arrest<br>Due to (or as a consequence of):<br>b. Multi organ Failure - Renal (Uremia)<br>Due to (or as a consequence of):<br>c. Pulmonary Hypertension - (COPD)<br>Due to (or as a consequence of):<br>d. Congestive Heart Failure - (CHF) |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Status Post: 1 Permanent Pacemaker<br>2 Cardiac - Venous Thrombosis<br>3 Leg Ulcer<br>Sepsis   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |
|   | 28a. Date of Injury (Month, Day, Year)<br>M   |  |  |  | 28b. Time of Injury<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how Injury occurred  |  |  |  |
|   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>James H. Colon   |  |  |  | 29c. License number<br>D20655  |  |  |  |
|   | 29d. Date signed (Month, Day, Year)<br>3/25/97  |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>611 S. Union Ave. Havre de Grace, Md. 21078  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br>MAR 27 1997  |  |  |  | 32. Registrar's Signature<br>Julia Davidson-Randall  |  |  |  |
|   | State Registrar   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09269

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Wilson, Judge

2. Date of Death

Month

Day

Year

3. Time of Death

3

26

97

2:15A.

4a. Facility Name (If not institution, give street and number)

2209 CECIL AVE

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

N/A

5. Social Security Number

215-07-2181

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2209 CECIL AVE

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4th

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

PORTER

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

BUTLER WILSON

18. Mother's Name (First, Middle, Maiden Surname)

ALICE Reda

19a. Informant's Name/Relationship (Type, Print)

MADELINE MATTHEWS/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2209 CECIL AVE - BALTO, MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD. NATL MEM PARK

Date

3/31/97

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

George Comartin

22. Name and Address of Facility

BETTS FUNERAL HOME

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ventricular arrhythmia

Due to (or as a consequence of):

Arteriosclerotic heart disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

c.

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7-10 days

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

Ca of Prostate

Recent pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Philip H. Moore M.D.

29c. License number

D12957

29d. Date signed (Month, Day, Year)

3/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip H. Moore 5601 Loch Raven Blvd. 21239 Balto Md.

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julie Wilson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1- Name wrong

19B



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09270

|   |   |  |   |   |  |  |  |
|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedant's Name (First, Middle, Last)<br><b>John Paul WILLHEIM</b>   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>22</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2:55 PM</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-05-7933</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 23, 1909</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedant   |  |   |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Essex</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>1032 Arncliffe Road</b>  |  |   | 10f. Zip Code<br><b>21221</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedant Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
|   | 15. Decedant's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10 Years</b>  |  | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steam Fitter</b>  |   | 16b. Kind of Business/Industry<br><b>Industrial</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Paul Willheim, Sr.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Not Known</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen J. Knight/Granddaughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1032 Arncliffe Road Essex, Maryland 21221</b> |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem. 3/25/1997</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, Maryland 21222</b>                          |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Spontaneous Pneumothorax</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>7 Days</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |  |
|   | 29b. Signature and title of certifier<br> <b>MD</b>  |  |   | 29c. License number<br><b>D46179</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/22/97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>11235 Oak Leaf Dr. # 905 Silver Spring, MD 20901</b> |   |  |   |   |  |  |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>   |  | 32. Registrar's Signature<br>  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09271

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David Womer

2. Date of Death

March 24 1997

3. Time of Death

10:05 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

212-34-7262

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 14, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7711 Fairgreen Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Navar Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance Broker

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Ben R. Womer

18. Mother's Name (First, Middle, Maiden Summa)

Kathryn Casserly

19a. Informant's Name/Relationship (Type, Print)

Jim Womer / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 297 Atlantic Beach, NC 28512

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Ph. 3/27/1997

Date

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Herniation of Brainstem

Due to (or as a consequence of):

5 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Intracerebral Hemorrhage

Due to (or as a consequence of):

6 hours

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

March 24 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Kennedy 600 N Wolfe St Baltimore MD

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

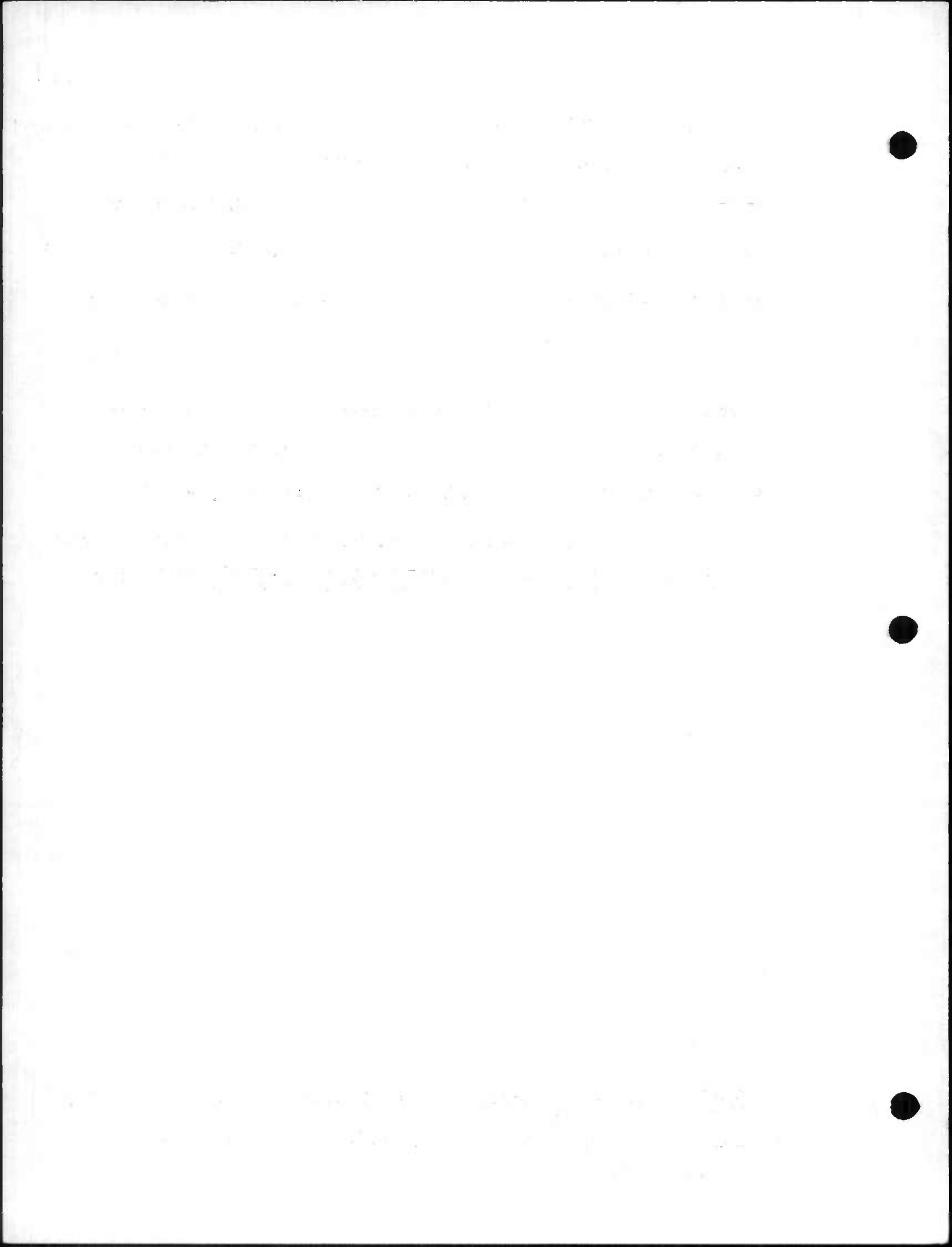
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 09272

Reg. No.

|   |   |   |  |  |  |  |   |  |
|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Charles Albert Walker, Sr.                      |   |  |  | 2. Date of Death<br>Month March 21 Day Year 1997 |  | 3. Time of Death<br>3:10 AM                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Montgomery County General |   |  |  | 4b. City, Town, or Location of Death<br>Olney    |  | 4c. County of Death<br>Montgomery                     |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-24-3954  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>69 Yrs.        |  | 8. Date of Birth (Month, Day, Year)<br>March 17, 1928 |  |
|   |   |   |  |  |  |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |
| Usual Residence of Decedent   |   |   |  |  |  |  |   |  |
| 10a. State<br>MD  |   | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Glen Burnie   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 10e. Street and Number<br>404 Oakwood Station Road  |   |   |  | 10f. Zip Code<br>21061   |  | 10g. Citizen of What Country?<br>United States   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1969  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Warehouse   |  | 16b. Kind of Business/Industry<br>US Government  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Harry Walker   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hattie Smallwood  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Leonarda Walker/ Wife   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>404 Oakwood Station Rd. Glen Burnie, MD 21061   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Good Shepherd Cemetery  |  | Data<br>3/24   |  | 20c. Location - City or Town, State<br>Ellicott City, MD   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road Laurel, Maryland 20707  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Ruptured thoracic aortic aneurysm with right hemothorax<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br>Days   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atherosclerotic cardiovascular disease  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br>D30868  |  | 29d. Date signed (Month, Day, Year)<br>March 21, 1997  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joan R Kumar MD 18101 Prince Philip Drive, Olney MD 20832   |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 27 1997  |   |   |  | 32. Registrar's Signature<br>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09273

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) JOHN WATSON 2. Date of Death Month 3 Day 22 Year 97 3. Time of Death 3:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) WATSON HOME HOSPITAL 4b. City, Town, or Location of Death BALTIMORE MD 4c. County of Death N/A

5. Social Security Number 220-42-7899 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 52 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) NOV 26, 1944 9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Baltimore 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 2401 N. Rolling Rd. 10f. Zip Code 21244 10g. Citizen of What Country? USA

11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mail Handler 16b. Kind of Business/Industry U.S. Postal Service

17. Father's Name (First, Middle, Last) Harmon Watson 18. Mother's Name (First, Middle, Maiden Surname) Goldie Johnson

19a. Informant's Name/Relationship (Type, Print) Martene Watson / wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 N. Rolling Rd. Baltimore, Maryland 21244

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park Date 3/26 20c. Location - City or Town, State Arbutus, Maryland

21. Signature of Funeral Service Licensee Kevin Parker 22. Name and Address of Facility Ken A. Parker Funeral Home 3512 Frederick Ave. Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) Sudden Cardiac Death Insomniac  
Due to (or as a consequence of):  
a. Acute Myocardial Infarction, Presumed Insomniac  
Due to (or as a consequence of):  
b. Atherosclerotic Coronary Artery Disease ~ 2 years  
Due to (or as a consequence of):  
c. Hypertension ~ Several years  
d. Diabetes

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of causa of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

29b. Signature and title of certifier Mark M. Applebaum 29c. License number D02512 29d. Date signed (Month, Day, Year) 3/24/97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Mark M. Applebaum MD 10000 Rockledge Drive Bethesda MD

31. Date filed (Month, Day, Year) MAR 27 1997 32. Registrar's Signature Lisa Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3: 17



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09274

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anne K. Wilson

2. Date of Death

March 25 1997

3. Time of Death

5:30 pm

4a. Facility Name (If not institution, give street and number)

Charlottesville Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-14-0348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 14, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

701 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Johnson Wax Products

17. Father's Name (First, Middle, Last)

Frank C. Woods

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn H. Hickey

19a. Informant's Name/Relationship (Type, Print)

Lucy W. Anderson (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

306 Lee Drive Catonsville, Maryland 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory, Inc. 1997

Date

March 28,

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Robert Guyon Buhner

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.  
1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matthew J. Norratt

29c. License number

D44748

29d. Date signed (Month, Day, Year)

March 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW J. NORRATT 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228

31. Date filed (Month, Day, Year)

MAR 27 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09275

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |   |   |   |  |
|---|---|---|--|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MELVIN FRANKLIN WILLIAMS</b>                 |   |  |   | 2. Date of Death<br>Month <b>MAR</b> Day <b>24</b> Year <b>'97</b> |   | 3. Time of Death<br><b>11:10 AM</b>                           |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>           |   | 4c. County of Death<br><b>N/A</b>                             |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-18-6824</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.                   |   | 8. Date of Birth (Month, Day, Year)<br><b>August 15, 1925</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                             |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>                                    |   | 10c. City, Town or Location<br><b>Baltimore</b>               |   |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>938 Coleridge Road</b>   |  | 10f. Zip Code<br><b>21229</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Brick Mason</b>   |   | 16b. Kind of Business/Industry<br><b>Construction</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Melvin Williams</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Garnet Lambert</b>  |   | 19. Informant's Name/Relationship (Type, Print)<br><b>Alice Williams (Wife)</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>  |  | 20c. Date<br><b>March 28, 1997</b>  |  | 20d. Location - City or Town, State<br><b>Dorsey, Maryland</b>  |   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |
| 22. Name and Address of Facility<br><b>Witzke Funeral Home of Catonsville, Inc.<br/>1630 Edmondson Avenue Catonsville, Maryland 21228</b>   |   | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PROSTATE CARCINOMA WITH METS 5 yrs</b>                                      |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                       |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.  |   | 29c. License number<br><b>P.O. 9886</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAR 24 '97</b>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>RUS VIOLETA ; ST. AGNES HOSP; 900 CATON AVE;</b> |   | 31. Date filed (Month, Day, Year)<br><b>MAR 27 1997</b>   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital-attending Physician: The law requires that the death certificate be executed within 24 hours after death.

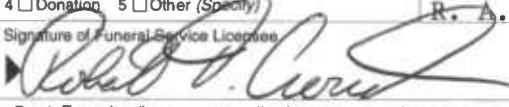
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



|   |  |  |   |   |  |  |  |   |   |  |
|---|--|--|---|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Charles Taylor Blackson</b>   |  |   |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>16</b> Year <b>1997</b>                          |   | 3. Time of Death<br><b>21:00</b>                            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital of Cecil County</b>                      |  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |   | 4c. County of Death<br><b>Cecil</b>                         |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>163-09-6205</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>October 12, 1914</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Cecil</b> 10c. City, Town or Location <b>Elkton</b> |  |   |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |
| 10e. Street and Number<br><b>302 West Pulaski Highway</b>   |  |  |   |   |  | 10f. Zip Code<br><b>21921</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b></b>   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b> |  |  | 16b. Kind of Business/Industry<br><b>Barge Manufacturing</b>                                   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Oscar Blackson</b>  |  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alfretta Rice</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Phyllis A. Bailer / Daughter</b>   |  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4911 Old Capital Trail, Wilmington, De 19808</b> |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R. A. Ferris Crematory</b>                       |  | Date<br><b>March 17 1997</b>   |  | 20c. Location - City or Town, State<br><b>West Chester, Penna.</b>      |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |   | 22. Name and Address of Facility<br><b>Crouch Funeral Home</b><br><b>127 South Main Street, North East, MD 21901</b>          |  |  |  |   |   |  |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>e. <b>Squamous Carcinoma - Metastatic</b><br>Due to (or as a consequence of):<br>5 months<br>f. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>15 years<br>g. <b>ASCVD</b><br>Due to (or as a consequence of):<br>10 years<br>h. <b>COPD</b><br>Due to (or as a consequence of): |  |  |   |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>- <b>Pneumonia.</b><br>- <b>CHF.</b>  |  |  |   |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |   |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |   |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |   |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   | 28d. Describe how injury occurred                           |  |
|   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Jui Chih Han MD</b>   |  |  |   |   |  | 29c. License number<br><b>DO4623</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/17/97</b>                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Jui Chih Han, MD 223 West main st. Elkton Md 21921</b>   |  |  |   |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>   |  |  |   |   |  |  |  |   |   |  |
| 32. Registrar's Signature<br>  |  |  |   |   |  |  |  |   |   |  |



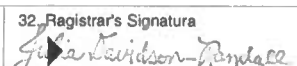
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09277

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                      | 1. Decedant's Name (First, Middle, Last)<br><b>Sophie Bratto</b>   |  |   |  | 2. Date of Death<br>Month <b>03</b> Day <b>08</b> Year <b>97</b>  |  |  |  | 3. Time of Death<br><b>3:00 Pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Caroline Nursing Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Denton</b>   |  |  |  | 4c. County of Death<br><b>Caroline</b>  |  |
| Funeral<br>Director                                    | 5. Social Security Number<br><b>087-18-8140</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>100</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 15, 1896</b>                         |  | 9. Birthplace (State or Foreign Country)<br><b>Hungaria</b>   |  |
|  | Usual Residence of Decedant  |  |   |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director                    | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Caroline</b>  |  | 10c. City, Town or Location<br><b>Denton</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  | 10e. Street and Number<br><b>520 Kerr Ave.</b>   |  |   |  | 10f. Zip Code<br><b>21629</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedant Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|  | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>08</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>  |  |   |  | 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>N/A</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>unknown Farkas</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sophie (unknown) Farkas</b>   |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Miriam Vitale/grandchild</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21 Dawes Ave., Amityville, NY 11701</b>   |  |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Templeville Cemetery</b>   |  | Date<br><b>3/13</b>   |  | 20c. Location - City or Town, State<br><b>Templeville, MD</b>                        |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Fleegle-Helfenbein Funeral Home<br/>Greensboro, MD</b>   |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>2w</b> |  |   |  |   |  |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure</b><br><b>Alzheimer's dementia</b>   |  |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |   |  |
| State<br>Registrar                                     | 29b. Signature and title of certifier<br> MD  |  |   |  | 29c. License number<br><b>D35284</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/10/97</b>   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 '97</b> |  | 32. Registrar's Signature<br> |   |  |   |  |  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 09278**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN LORETTA BARKER

2. Date of Death

Month Day Year  
MARCH 11, 1997

3. Time of Death

7:00 PM

4a. Facility Name (If not institution, give street and number)

CUPPETT &amp; WEEKS NURSING HOME

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

Funeral  
Director

5. Social Security Number

212-44-3603

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 17 1945

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1472 MEMORIAL DRIVE

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

Collage (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

BUYER

16b. Kind of Business/Industry

FOOD SERVICE

17. Father's Name (First, Middle, Last)

HOWARD

BARKER

18. Mother's Name (First, Middle, Maiden Surname)

LaRUE

SNYDER

19a. Informant's Name/Relationship (Type, Print)

THOMAS DRANKIEWICZ - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 473

OAKLAND, MD 21550

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

OMEGA CREMATORY


Date

3/13/97

20c. Location - City or Town, State

MORGANTOWN, W. VA.

21. Signature of Funeral Service Licensee

 MO0167

22. Name and Address of Facility

P.O. BOX 243  
DURST FUNERAL HOME - OAKLAND, MD. 2155023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Poorly Differentiated Carcinoma Lung 2 years

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

metastasis to Brain

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

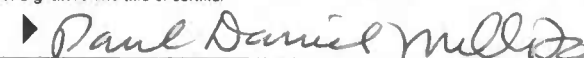
27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

H26154

29d. Date signed (Month, Day, Year)

MARCH 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

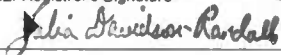
P. DANIEL MILLER, D.O. 2008 MARYLAND HIGHWAY

MT. LAKE PARK, MD 21550

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09279

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAISY P. BROWN

2. Date of Death

Month

Day

Year

March 14 1997

3. Time of Death

0130

4a. Facility Name (If not institution, give street and number)

Deaton Hospital and Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

419-64-5605

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
OCT 1 1948

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Baltimore City

Baltimore

1 ☒ Yes 2 ☐ No

10e. Street and Number

611 St Charles Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Clarence Poole

18. Mother's Name (First, Middle, Maiden Surname)

Willie Lee Streety

19a. Informant's Name/Relationship (Type, Print)

Regina Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1817 Hale St Montgomery, Alabama 36104

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee's Funeral Home

Date

3-17-97

20c. Location - City or Town, State

Montgomery, Alabama

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary

4433 WhitePls La White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Sepsis

Approximate Interval Between Onset and Death

Days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anoxic encephalopathy

HTM cause disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D28998

March 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PRITAM S SAHNI MD

9101 Cherry LN # 211

Lanham MD 20708

31. Date filed (Month, Day, Year)

MAR 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09280

Reg. No.

|  |   |                                |   |  |   |  |   |   |
|--|---|--------------------------------|---|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD P. Bivens</b>  |                                |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>17</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1120</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |                                |   |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |  | 4c. County of Death<br><b>WICOMICO</b>                                  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-82-5674</b>   |                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>11-06-1963</b>                | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
|  | Usual Residence of Decedent   |                                |   |  |   |  |   |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Somerset</b> | 10c. City, Town or Location<br><b>Princess Anne</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
|  | 10e. Street and Number<br><b>30512 Nutters Lane Apt 20</b>  |                                |   |  | 10f. Zip Code<br><b>21853</b>   |  | 10g. Citizen of What Country?<br><b>U.S.</b>                            |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>laborer</b>                       |  | 16b. Kind of Business/Industry<br><b>Truck Driver</b>   |  |   |   |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>LEONARD A. BIVENS</b>   |                                |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CELESTE DENNIS</b>  |  |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Celeste DENNIS / Mother</b>  |                                |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>30512 Nutters Lane Apt 20 Princess Anne, MD 21853</b>   |  |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. CHARLES Cemetery</b>   |  | Date<br><b>3-22-97</b>  | 20c. Location - City or Town, State<br><b>CHANCE, MD</b>                                       |   |   |
|  | 21. Signature of Funeral Service Licensee<br>   |                                | 22. Name and Address of Facility<br><b>Anthony E. Ward Funeral Home<br/>30639 Hampden Ave. Princess Anne, MD 21853</b>                            |  |   |  |   |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. AIDS</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |                                |   |  |   |  |   |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                                |   |  |   |  |   |   |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |   |  |   |  |   |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |                                |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  |   |   |
|  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred                                       |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                      |                                |   |  | 29b. Signature and title of certifier<br>   |  |   |   |
| State Registrar  | 29c. License number<br><b>D32019</b>  |                                |   |  | 29d. Date signed (Month, Day, Year)<br><b>3/17/97</b>   |  |   |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W. WOODRUFF 547 E RIVERSIDE DRIVE SALEM Bury MD 21801</b>  |                                |   |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 1997</b>              |   |                                |   | 32. Registrar's Signature<br>                    |   |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09281

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |  |  |  |
|--|--|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Ruth W. Barber</i>  |   |   |   | 2. Date of Death<br>Month <i>March</i> Day <i>12</i> Year <i>97</i>   |  | 3. Time of Death<br><i>12:50</i>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>University of Maryland Medical System Baltimore</i>   |   |   |   | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death<br><i>N/A</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>212-09-9185</i>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>84</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>Aug. 28, 1912</i>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |   | 10a. State<br><i>Maryland</i>   |   | 10b. County<br><i>Carroll</i>   |  | 10c. City, Town or Location<br><i>Sykesville</i>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><i>2414 Liberty Road</i>  |   | 10f. Zip Code<br><i>21784</i>   |  | 10g. Citizen of What Country?<br><i>United States</i>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Housewife</i>   |   | 16b. Kind of Business/Industry<br><i>own home</i>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>C. Bradley Ward</i>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Cora Schaeffer</i>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Kathleen Weaver Daughter</i>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>HCR 71 Box 500 Orbisonia, PA 17243</i> |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Kriders Cemetery</i>   |   | 20c. Location - City or Town, State<br><i>Westminster, MD</i>   |  | 20d. Date<br><i>3/15/97</i>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>James B. Covey</i>   |   | 22. Name and Address of Facility<br><i>Burrier-Queen Funeral Directors, P.A.<br/>1212 W. Old Liberty Road Winfield, MD 21784</i>  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <i>subarachnoid hemorrhage</i><br>Due to (or as a consequence of):<br>b. <i>intracerebral aneurysm</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><i>24 hours</i>  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><i>March 12, 1997</i>  |  |
|  | 28b. Time of Injury<br><i>M</i>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>James B. Covey</i>  |   | 29c. License number<br><i>P10036</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>March 12, 97</i>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Barbara L. Greer MD, 22 S. Greene St. Baltimore, MD 21201</i> |  | 31. Date filed (Month, Day, Year)<br><i>MAR 14 1997</i> |   | 32. Registrar's Signature<br><i>John Andrew Randall</i> |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09282

## Certificate of Death

Reg. No.

|   |   |  |   |                                |   |  |  |  |
|---|---|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>DOROTHY BOUKNIGHT   |  |   |                                | 2. Date of Death<br>Month 03 Day 11 Year 1997   |  | 3. Time of Death<br>8:45 AM                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>16339 Pennsbury Way   |  |   |                                | 4b. City, Town, or Location of Death<br>Bowie   |  | 4c. County of Death<br>Prince George's                           |  |
| Funeral<br>Director   | 5. Social Security Number<br>195-14-7996  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>80 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>09-07-1916  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania         |  |
|   | Usual Residence of Decedent   |  |   |                                |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Prince George's   | 10c. City, Town or Location<br>Bowie  |                                |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>16339 Pennsbury Way   |  |   | 10f. Zip Code<br>20716         |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th<br>Collega (1-4or 5+) 11th  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Practical Nurse                          |                                |   | 16b. Kind of Business/Industry<br>Government   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Edward Warring   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mamie Robinson   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Laverne Warring Dunbar/Niece  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16339 Pennsbury Way, Bowie, Maryland 20716   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Park Rolling Green Memorial   |                                | 20c. Location - City or Town, State<br>West Chester, PA   |  | 20d. Date<br>03/18/1997  |  |
|   | 21. Signature of Funeral Service Licensee<br>Nancy A. Perentis  |  |   |                                | 22. Name and Address of Facility<br>J. B. JENKINS FUNERAL HOME<br>7474 Landover Rd, Landover, Maryland 20785  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Coronary Artery disease<br>Due to (or as a consequence of):<br>b. Myocardial infarction<br>Due to (or as a consequence of):<br>c. Cardiac arrhythmia<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Not available   |  |   |                                |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |                                | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |
|   | 28a. Date of Injury (Month, Day, Year)<br>3-11-97   |  | 28b. Time of Injury<br>? M  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br>N/A                         |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>N/A   |  |   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Home  |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                | 29b. Signature and title of certifier<br>[Signature]  |  |  |  |
|   | 29c. License number<br>D09179   |  |   |                                | 29d. Date signed (Month, Day, Year)<br>3-12-97  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Hta O. Moshych, MD 7305 Hanover Pkwy A. Greenbelt, MD 20770   |  |   |                                |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>MAR 14 1997  |  |   |                                | 32. Registrar's Signature<br>[Signature]  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09283

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wesley C. Baylis

2. Date of Death

March 11, 1997

3. Time of Death

11:12 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

069-10-5085

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 17, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11207 Lochton Street

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Consulting Engineer

16b. Kind of Business/Industry

Own Business

17. Father's Name (First, Middle, Last)

Joseph Mills Baylis

18. Mother's Name (First, Middle, Maiden Surname)

Emma Charlotte Vandervoort

19a. Informant's Name/Relationship (Type, Print)

Richard Baylis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1700 Sherwood Avenue, Baltimore, Md. 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Cemetery

Date

3/15/97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, 4739  
Baltimore Avenue, Hyattsville, Md. 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Myocardial infarction*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Hypertension*  
Due to (or as a consequence of):

years

c. *Diabetes mellitus*  
Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D16191

29d. Date signed (Month, Day, Year)

3/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10694 Campus Way S, Largo, Md. 20774 - James J. Kim, M.D.

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

John A. ...

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09284

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |   |   |  |  |
|---|--|--|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Frieda Gertrude BELL</b>                              |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>7</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>4:32AM</b>                                       |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctor's Community Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>  |   | 4c. County of Death<br><b>Prince George's</b>                           |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-24-0400</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>March 8, 1904</b>             |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Annapolis</b>                         |  |  |
| Usual Residence of Decedent   |  |  |  |  |  |   |   |  |  |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |  |  | 10e. Street and Number<br><b>132 East Bay View Drive</b>   |  |  | 10f. Zip Code<br><b>21403</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:          |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>7</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembler</b>  |  |  | 16b. Kind of Business/Industry<br><b>National Security Administration</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frederick Ehoff</b>   |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie Johanna Stanig</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lillian B. Roy - Daughter</b>  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>132 East Bay View Drive, Annapolis, Maryland 21403</b> |   |   |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>G. Washington Cemetery</b>  |  | Date<br><b>03/11/97</b>  |   | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>         |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  |  | 22. Name and Address of Facility<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>                        |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac Arrest</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>c. Hypertension</b><br>Due to (or as a consequence of):<br><b>d. Angina</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>10 yrs<br/>10 yrs<br/>3-4 yrs</b> |  |  |  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Osteoarthritis</b>  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |   |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending investigation <b>6</b> Could not be determined   |  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  |  |
| 28d. Describe how injury occurred   |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  |  |  |  | 29c. License number<br><b>D34722</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3-7-97</b>                    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vicken Poochikian, 5632 Annapolis Road, Suite 3, Bladensburg, MD 20710</b>   |  |  |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 10 1997</b>   |  |  | 32. Registrar's Signature<br>   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



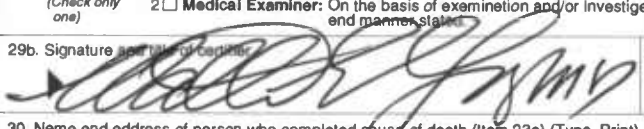
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09285

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |   |                                |   |  |  |  |
|--|--|---|--|--|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James Burgess</b>                             |   |  |  | 2. Date of Death<br>Month Day Year<br><b>March 5, 1997</b>   |   |                                |   | 3. Time of Death<br><b>2:30 P.M.</b>   |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b> |   |                                |   | 4c. County of Death<br><b>Montgomery</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>104-16-1885</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.             |   | If Under 1 Year<br>Months Days |   | 8. Date of Birth (Month, Day, Year)<br><b>2/6/17</b>   |  |  |
|  | 10a. State<br><b>D.C.</b>  |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Washington</b>             |   |                                |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>5929 E. Capitol St., S.E. # 202</b>   |  | 10f. Zip Code<br><b>20019</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |                                |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b>  |  | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Guard</b>   |  |   |                                | 16b. Kind of Business/Industry<br><b>Private Industry</b>               |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Daniel Burgess</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lizza Richards</b>   |  |   |                                |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Daniel Bethea/Friend</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7710 Orange Tree Ct., Cap. Hgts., Md. 20743</b>  |  |   |                                |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Mem. Cem.</b>  |  | Date<br><b>3/14/97</b>   |  | 20c. Location - City or Town, State<br><b>Suitland, Md.</b>                                 |                                |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>H.S. Washington &amp; Sons, Inc.<br/>4925 Burroughs Ave., N.E</b>   |  |   |                                |   |  |  |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |                                |   |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Urosepsis</b><br>Due to (or as a consequence of):<br><b>Prostate Cancer</b>   |  |   |  |  |  |   |                                |   |  | 2 weeks  |  |
| b. Due to (or as a consequence of):  |  |   |  |  |  |   |                                |   |  |  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |  |   |                                |   |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |  |   |                                |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Insufficiency</b>   |  |   |  |  |  |   |                                |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  |   |                                |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  |   |                                |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |                                |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                | 28d. Describe how injury occurred                                       |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and Title of Certifier<br>  |  |  |  | 29c. License number<br><b>D01120</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>March 10, 1997</b>            |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Wla Walter E. Goozh, M.D. 2309 Shorefield Rd., Wheaton, Md. 20902</b>   |  |   |  |  |  |   |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |                                |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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State of Maryland / Department of Health and Mental Hygiene

97 09286

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |   |   |
|---|--|---|---|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Norris Linwood Craft, Sr.  |   |   |   | 2. Date of Death<br>Month Day Year<br>March 17, 1997   |  | 3. Time of Death<br>11:00AM                                      |   |   |
|   | 4a. Facility Name (If not institution, give street and number)   |   |   |   | 4b. City, Town, or Location of Death<br>Reliance   |  | 4c. County of Death<br>Dorchester                                |   |   |
| Funeral<br>Director   | 5. Social Security Number<br>213-18-4461   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>75 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)  |  | 9. Birthplace (State or Foreign Country)  |   |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br>MD   | 10b. County<br>Dorchester   | 10c. City, Town or Location<br>(Reliance) Seaford   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |
|   | 10e. Street and Number<br>6046 Oriole Drive  |   |   | 10f. Zip Code<br>19973  |  | 10g. Citizen of What Country?<br>United States   |  |   |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |   |   | 15e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Supervisor |  | 16b. Kind of Business/Industry<br>E.I. DuPont Co.  |  |   |   |
|   | 17. Father's Name (First, Middle, Last)<br>Albert Chester Craft  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Edith Mae Todd  |  |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Helen H. Craft/Spouse  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6046 Oriole Dr., Seaford, DE 19973  |  |  |   |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                      |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hill Crest Cemetery   |   | Date<br>3/20   |  | 20c. Location - City or Town, State<br>Federalsburg, MD          |   |   |
|   | 21. Signature of Funeral Service Licensee<br>Michael F. Eskow  |   |   |   | 22. Name and Address of Facility<br>Frampton-Hawkins-Eskow Funeral Home<br>PO Box 43, Federalsburg, MD 21632   |  |  |   |   |
|   | 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death    |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. Ventricular Fibrillation<br>Due to (or as a consequence of):<br>b. Coronary artery disease<br>Due to (or as a consequence of):<br>c. Ischemic Cardiovascular Disease<br>Due to (or as a consequence of):<br>d. |   |   |   |  |  |  |   | 0<br>greater than 10 yrs<br>greater than 10 yrs |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |   |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |
|   |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |  |  |   |   |
| 29b. Signature and title of certifier<br>[Signature]  |  |   |   | 29c. License number<br>D 11020  |  | 29d. Date signed (Month, Day, Year)<br>03/19/97  |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>128 Bloomingdale Ave., Federalsburg, Maryland 21632   |  |   |   |   |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br>MAR 19 '97   |  |   |   | 32. Registrar's Signature<br>[Signature]  |  |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09287

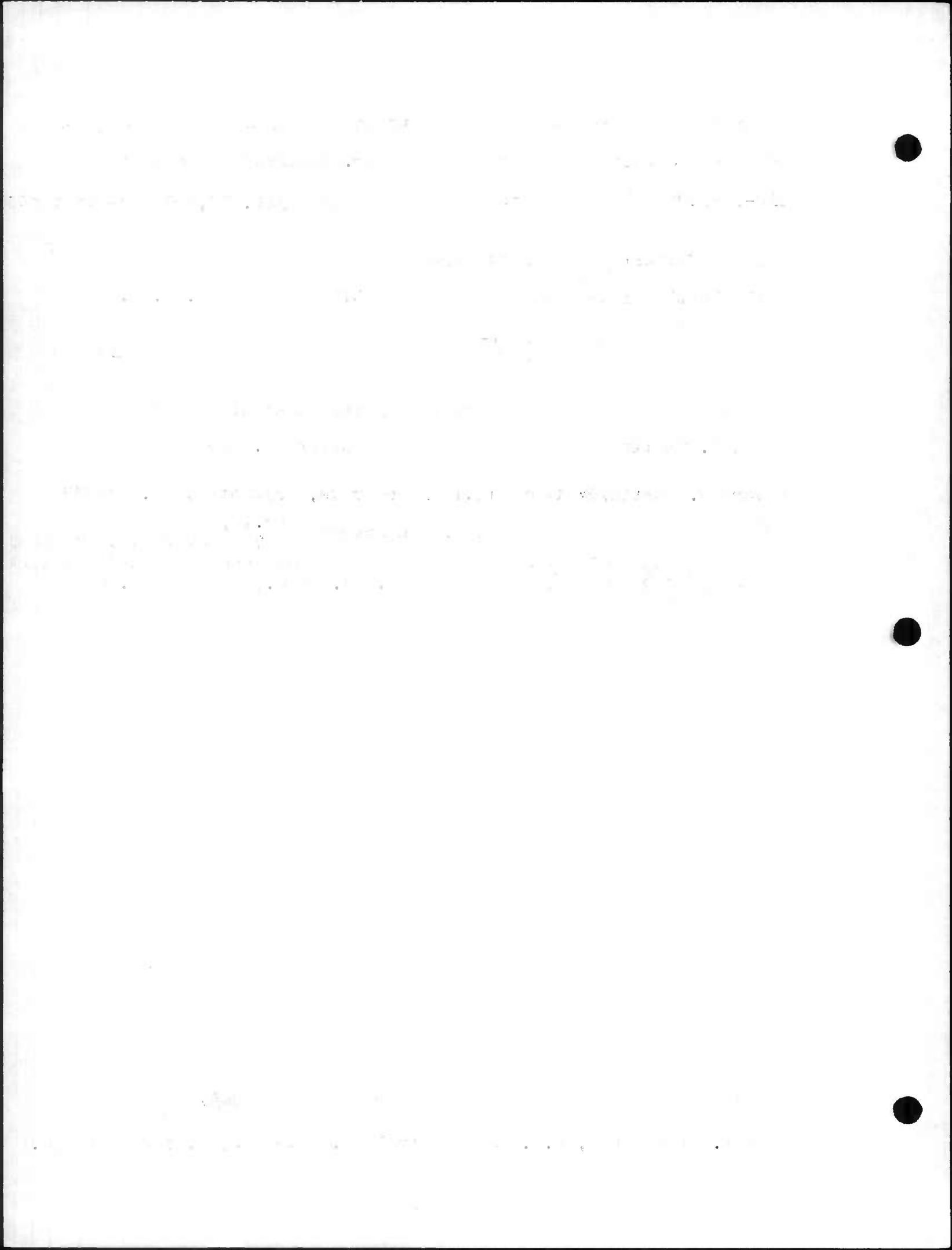
## Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |  |
|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Charles Lawrence Curtin   |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 10, 1997  |   | 3. Time of Death<br>22:31  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Calvert Memorial Hospital   |  |  | 4b. City, Town, or Location of Death<br>Pr. Frederick   |   | 4c. County of Death<br>Calvert   |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-34-3896  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>58 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 23, 1939   |
|  | 9. Birthplace (State or Foreign Country)<br>Washington DC   |  |  |   |   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |  |   |   |  |  |
|  | 10a. State<br>MD  |  | 10b. County<br>Calvert   |   | 10c. City, Town or Location<br>Port Republic  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br>5150 Turtle Creek Road  |  |  | 10f. Zip Code<br>20676  |   | 10g. Citizen of What Country?<br>U. S. A.  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1961-<br>If Yes, Give Year or Dates: 1965 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Computer Systems Analyst   |   | 16b. Kind of Business/Industry<br>PEPCO  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John D. Curtin   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Cleora E. Lee  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Edward F. Curtin/Brother  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1411 Shore Drive, Edgewater, Md. 21037 |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery  |   | 20c. Location - City or Town, State<br>Mar. 14, 1997 Suitland, Maryland   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  | 22. Name and Address of Facility<br>Lee Funeral Home Calvert, PA<br>1825 So. Md. Blvd., Owings, Md. 20736                               |   |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. HYPOXIC ENCEPHALOPATHY<br>Due to (or as a consequence of):<br>b. SEIZURE DISORDER<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate interval Between Onset and Death<br>3 WEEKS<br>3 WEEKS |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ASPIRATION PNEUMONIA<br>SEPSIS<br>QUADRAPLEGIA   |   |  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |   |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year) |  | 28b. Time of injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  |   | 28d. Describe how injury occurred      |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |   |  | 29c. License number<br>D 40370   |   | 29d. Date signed (Month, Day, Year)<br>MAR/11/97  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Peter L. Wisniewski, M.D. 120 Hospital Rd. Suite 200, Pr. Frederick, Md.   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 13 1997   |   | 32. Registrar's Signature<br>          |  |   |   |  |  |
| State Registrar  |   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

97 09288

Reg. No.

|  |  |                                    |   |  |  |   |   |  |   |  |
|--|--|------------------------------------|---|--|--|---|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><u>Susie Carroll</u>                                       |                                    |   |  |  | 2. Date of Death<br>Month <u>March</u> Day <u>3</u> Year <u>1997</u>  |   | 3. Time of Death<br><u>4:00 AM</u>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Washington Adventist Hospital</u> |                                    |   |  |  | 4b. City, Town, or Location of Death<br><u>Takoma Park</u>            |   | 4c. County of Death<br><u>Montgomery</u>   |   |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><u>214-20-5162</u>  |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>90</u> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><u>Sept. 23, 1906</u>                                |  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u> |  |
|  | Usual Residence of Decedent  |                                    |   |  |  |   |   |  |   |  |
| 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Anne Arundel</u> |   | 10c. City, Town, or Location<br><u>Lothian</u> |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><u>320 West Bayfront Road</u>  |  |                                    |   |  | 10f. Zip Code<br><u>20711</u>  |   | 10g. Citizen of What Country?<br><u>USA</u>   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+)  |  |                                    |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Domestic</u>   |   |   | 16b. Kind of Business/Industry<br><u>Someone else's home</u>                                   |   |  |
| 17. Father's Name (First, Middle, Last)<br><u>Ernest (Buddy) Price</u>   |  |                                    |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Beatrice Hawkins</u>   |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Winifred Spriggs/POA</u>  |  |                                    |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>320 West Bayfront Rd. Lothian, MD 20711</u>  |   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Mt. Gethsemane Chr. Cem.</u>   |  |  | 20c. Location - City or Town, State<br><u>3/14/97 Huntingtown, MD</u> |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><u>Spencer E. Sewell</u>  |  |                                    |   |  | 22. Name and Address of Facility<br><u>Sewell Funeral Home</u><br><u>1451 Dares Beach Rd. Prince Frederick, MD 20678</u>   |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>SEPSIS</u></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>b. _____</p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>c. _____</p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><u>~ 4 days</u></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> |  |                                    |   |  |  |   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                    |   |  |  |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                                    |   |  |  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |   |  |  |   |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |                                    |   |  |  |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |                                    | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                    |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                    |   |  |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><u>M. S. Nayar</u>  |  |                                    |   |  | 29c. License number<br><u>D-17874</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>3-10-97</u>                                       |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>S. M. NAYAR, MD, 3717-38th AVE COTTAGE CITY, MARYLAND 20722</u>   |  |                                    |   |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>MAR 14 1997</u>  |  |                                    | 32. Registrar's Signature<br><u>J. Davidson-Randall</u>   |  |  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09289

## Certificate of Death

Reg. No.

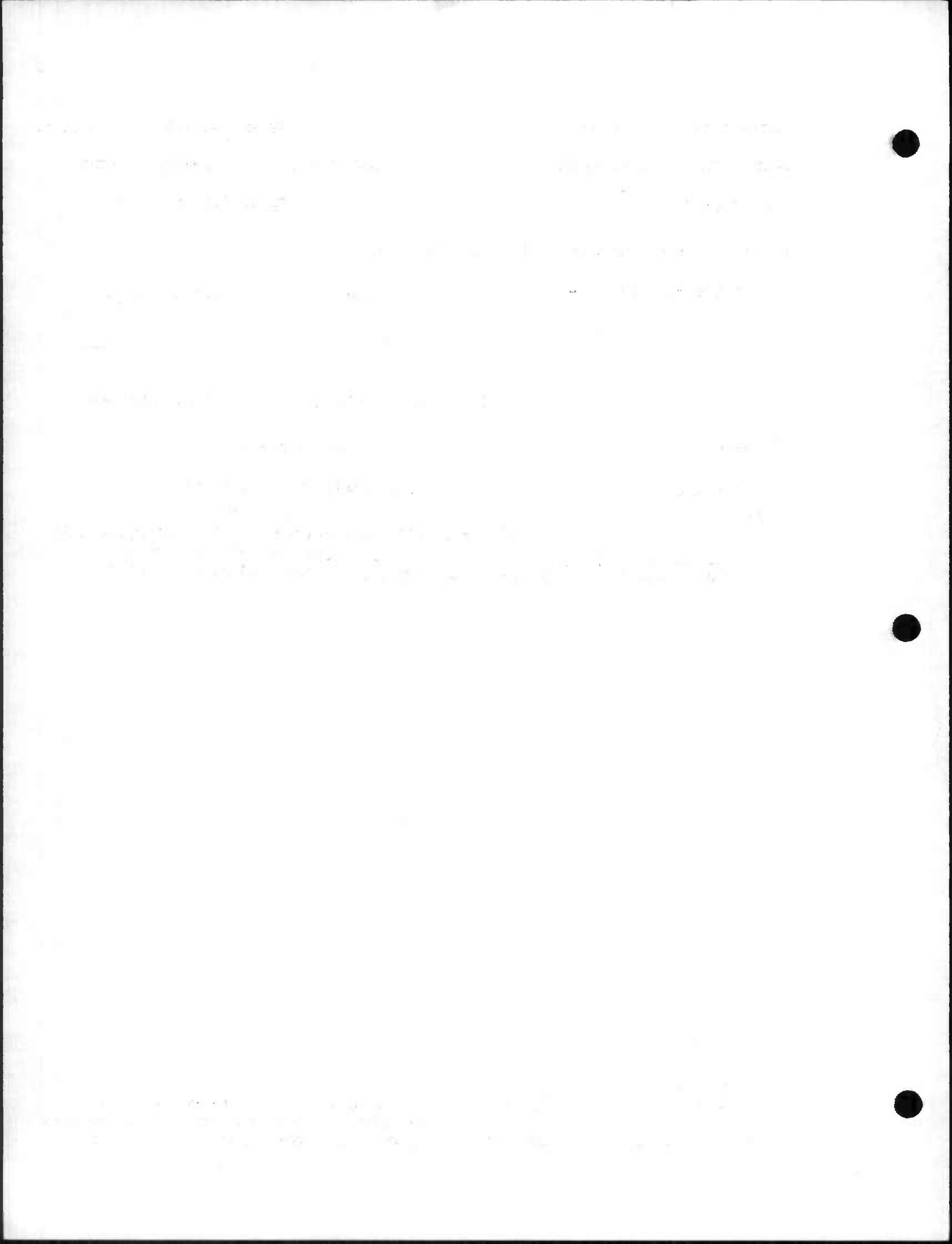
|  |  |   |  |  |  |   |   |  |  |  |  |
|--|--|---|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LESTER EUGENE CROSBY</b>                              |   |  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 14, 1997</b>             |  | 3. Time of Death<br><b>10:55 A.M.</b>                    |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MALCOLM GROW MEDICAL CENTER</b> |   |  |  |  |   | 4b. City, Town, or Location of Death<br><b>ANDREWS AFB</b>              |  | 4c. County of Death<br><b>PRINCE GEORGES</b>             |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>002-12-6872</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>April 4, 1928</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>Maine</b> |  |  |
|  | Usual Residence of Decedent  |   |  |  |  |   |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>District Heights</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>2109 Springholly Drive</b>  |  |   |  | 10f. Zip Code<br><b>20747</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Air Force Chief Master Sgt.</b>  |  |   | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Merton Crosby</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Amelia Crane</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Timothy Crosby</b>  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>305 Marganza South, Laurel, Maryland 20724</b>                            |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>  |  |  | Date<br><b>March 21, 1997</b>                    |   | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>       |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  |  |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</b>  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARDIOPULMONARY ARREST</b><br>Due to (or as a consequence of):<br><b>b. METASTATIC HORMONE RESISTANT PROSTATE CANCER</b><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |   |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |  |  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><br><b>William S. Sykora</b>  |  |  |  |   |   | 29c. License number<br><b>27148 CO.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 14, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM S. SYKORA, LTCOL, USAF, MD</b>  |  |   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>89 MEDICAL GROUP 1050 WEST PERIMETER ROAD ANDREWS AIR FORCE BASE MD 20762-6600</b> |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09290

|  |   |  |   |  |  |                                |  |  |
|--|---|--|---|--|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>PATRICIA LEE CARDONE</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>14</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>5:30 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-54-2676</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>FEB 2, 1949</b>                                      |  |
|  | Usual Residence of Decedent   |  |   |  |  |                                | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CARROLL</b>   |  | 10c. City, Town or Location<br><b>HAMPSTEAD</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>4713 MT. CARMEL ROAD</b>   |  |   |  | 10f. Zip Code<br><b>21074</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>6</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |                                |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>H.P. CRAWFORD</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NORMA TERAMANI</b>   |                                |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DOMINIC M. CARDONE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4713 MT. CARMEL ROAD, HAMPSTEAD, MD 21074</b>  |                                |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HAMPSTEAD CEMETERY</b>   |  | Date<br><b>3/17</b>  |                                | 20c. Location - City or Town, State<br><b>HAMPSTEAD, MD</b>                                    |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Steven W. Elmer</b>   |  | 22. Name and Address of Facility<br><b>ELINE FUNERAL HOME<br/>934 S MAIN ST, HAMPSTEAD, MD 21074</b>  |  |  |                                |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Carcinoma of Lung</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>unknown</b> |  |   |  |  |                                |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SCHIZOPHRENIA</b><br><b>DIABETIC MELLITUS</b>  |  |   |  |  |                                |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |                                |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.       |  | 29b. Signature and title of certifier<br><b>Charles B. Conaway MD</b>   |  | 29c. License number<br><b>D19502</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH 14, 1997</b>                                   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ORLANDO B. CONAWAY MD, NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD, 21133</b>   |  |   |  |  |                                |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAR 17 1997</b>   |  | 32. Registrar's Signature<br><b>John A. Swisher</b>   |  |  |                                |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>EDNA RUTH CROUSE   |  |   |  | 2. Date of Death<br>Month Day Year<br>March 10, 1997  |  | 3. Time of Death<br>0725a  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>61 RALPH STREET  |  |   |  | 4b. City, Town, or Location of Death<br>WESTMINSTER   |  | 4c. County of Death<br>CARROLL   |  |
| Funeral<br>Director   | 5. Social Security Number<br>176-07-8998   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 25, 1912                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  | 10a. State<br>Maryland  |  | 10b. County<br>Carroll  |  | 10c. City, Town or Location<br>Westminster   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>61 Ralph Street   |  | 10f. Zip Code<br>21157  |  | 10g. Citizen of What Country?<br>United States                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>11   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife                                |  | 16b. Kind of Business/Industry<br>Domestic  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Cashman   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Minnie Snyder  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Caroline Seamon  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8004 Yellowstone Rd, Kingsville, MD 21087  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br>Evergreen Memorial Gardens 3/13  |  | 20c. Location - City or Town, State<br>Finksburg, Maryland  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Robert A. Myers</i>  |  |   |  | 22. Name and Address of Facility<br>Myers Funeral Home<br>91 Willis Street, Westminster, MD 21157   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Arteriosclerotic Cardiovascular Disease</i><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Robert A. Myers</i>  |  |   |  | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>March 10, 1997                                |  |
|   | 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br>J. LARON WICK, MD 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |   |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>MAR 13 1997   |  |   |  | 32. Registrar's Signature<br><i>J. Laron Wick</i>   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09292

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |                                   |  |  |
|---|---|--|---|--|--|--|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>William Thomas Crowder  |  |   |  | 2. Date of Death<br>Month Day Year<br>March 6, 1997  |  |   |                                   | 3. Time of Death<br>9:15PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>11017 Riverview Rd.   |  |   |  | 4b. City, Town, or Location of Death<br>Fort Washington  |  |   |                                   | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director   | 5. Social Security Number<br>224-32-1629  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>68 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>June 26, 1928        |                                   | 9. Birthplace (State or Foreign Country)<br>New Jersey   |  |
|   | Usual Residence of Decedent   |  |   |  | 10a. State<br>Maryland   |  | 10b. County<br>Prince George's                              |                                   | 10c. City, Town or Location<br>Fort Washington   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 10e. Street and Number<br>11017 Riverview Rd.  |  | 10f. Zip Code<br>20744                                      |                                   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1945-46 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |   |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Self Employed   |  |   |                                   | 16b. Kind of Business/Industry<br>Moving Business  |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Washington Crowder  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Beatrice Cole  |  |   |                                   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Carol A. Crowder / Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11017 Riverview Rd. Ft. Washington, Md. 20744   |  |   |                                   |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  | 20c. Date<br>3/7/97  |  | 20d. Location - City or Town, State<br>Alexandria, Virginia |                                   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>George P. Kalas</i>   |  |   |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745  |  |   |                                   |  |  |
|   | 23a. Part I. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC CANCER OF THE PROSTATE<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>1993   |  |   |                                   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |                                   |  |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |   | 28. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |                                   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                 |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |                                   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>David H. Hirsch MD</i>   |   | 29c. License number<br>D28768  |  | 29d. Date signed (Month, Day, Year)<br>3/07/1997                                     |   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MARIA A. EISENBERGER 600 N. WOLFE ST #173 BALTIMORE, MD 21287   |   | 31. Date filed (Month, Day, Year)<br>MAR 10 1997   |   | 32. Registrar's Signature<br><i>Salvatore A. Russell</i>   |  |  |   |                                   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

224

1944-1945

7788. 24.

1994

... ..

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09293

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |   |  |  |
|---|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET R. DANIELS</b>  |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>13</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>12:30 pm</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1110 Sassafras Rd.</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Golts</b>   |   | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-16-5367</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>2-23-1920</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Golts, MD.</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Cecil</b>  |   | 10c. City, Town or Location<br><b>Golts</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>1110 Sassafras Rd.</b>  |   | 10f. Zip Code<br><b>21635</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-46</b> |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                      |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Domestic</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry E. Robinson</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Belle Price</b>  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Howard Daniels - husband</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1110 Sassafras Rd., Golts, MD. 21635</b>                                   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Townsend Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>3-17-97 Townsend, Delaware</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>DANIELS &amp; HUTCHISON FUNERAL HOME<br/>212 N. Broad St., Middletown, DE. 19709</b>  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>COPD</b><br>Due to (or as a consequence of):<br><b>Pulmonary Fibrosis</b><br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death<br><b>2 wks</b><br><b>years</b>   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |  |  | 29c. License number<br><b>CI-0000925</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3-17-97</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary T. Quiroga, MD 1027 S. Bradford Street, Dover 19901</b>   |   |  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 17 1997</b>  |  |   |  |  |
| 32. Registrar's Signature<br>   |   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





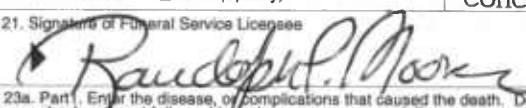
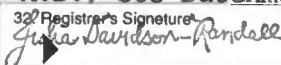
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09294

## Certificate of Death

Reg. No.

|   |   |  |   |                                |  |
|---|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Dill</b>  |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>9:54PM</b>  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>The Memorial Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Easton</b>   |                                | 4c. County of Death<br><b>Talbot</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-32-8808</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>December 12, 1935</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |                                |  |
|   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Caroline</b>   | 10c. City, Town or Location<br><b>Denton</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>7881 Dyer Road</b>   |  | 10f. Zip Code<br><b>21629</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>       |                                |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>   |                                |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ralph Tilghman Dill</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Florence Jester</b>  |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Myrna G. Dill Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7881 Dyer Road, Denton, Maryland 21629</b>    |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Concord Cemetery</b>   |                                | 20c. Location - City or Town, State<br><b>3/16 Denton, Maryland</b>  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Moore Funeral Home, P.A.<br/>12 South Second Street, Denton, MD 21629</b>                                  |                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Lung cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |   |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |  |   |                                |  |
| 28a. Date of Injury (Month, Day Year)<br><b>3/12/97</b>   |   |  |   |                                |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |   |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |
| 28d. Describe how injury occurred   |   |  |   |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |                                |  |
| 29b. Signature and title of certifier<br>  |   |  |   |                                |  |
| 29c. License number<br><b>039749</b>  |   |  |   |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/12/97</b>   |   |  |   |                                |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Gregg David Oliver, M.D., 503 Dutchmen's Lane, Easton, MD 21601</b>  |   |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 '97</b>  |   |  |   |                                |  |
| 32. Registrar's Signature<br>  |   |  |   |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09295

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE VERNON

DUVALL JR.

2. Date of Death

Month

Day

Year

MAR

14

1997

3. Time of Death

10:27 PM

4a. Facility Name (If not institution, give street and number)

PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

214-82-0688

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC 18 1947

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5147 Amber Jack Court

10f. Zip Code

20603

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

George Duvall Sr

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Fincham Duvall

19a. Informant's Name/Relationship (Type, Print)

Thomas E. Fincham (Uncle)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7070 Cradle Rock Way Columbia, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union Cemetery

Date

3-17-97

20c. Location - City or Town, State

Spincerville, MD

21. Signature of Funeral Service Licensee

John A. Eberwein M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary  
4433 White Pls Lane White Pls., MD 2069523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Multiple Organ System Failure

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c. Respiratory Failure

Due to (or as a consequence of):

d. Chronic Megacolon

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mental Retardation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office,  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Eberwein

29c. License number

D-00560

29d. Date signed (Month, Day, Year)

3/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIRENDRA BHADURI MD 6 POST OFFICE RD. #101 WALDORF, MD 20604

31. Date filed (Month, Day, Year)

MAR 1 8 1997

32. Registrar's Signature

John A. Eberwein

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09296

Items: 23 part 1, 27 per MEO G-746 4/1/97 re Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

KENNETH ROBERT DEVILBISS

2. Date of Death  
Month Day Year

March 11, 1997

3. Time of Death

646p

4a. Facility Name (If not institution, give street and number)

CARROLL COUNTY GENERAL

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

220-48-0589

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Dec. 28, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3858 Littlestown Pike

10f. Zip Code

21158

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1969-1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

metal mechanic

16b. Kind of Business/Industry

sheet metal

17. Father's Name (First, Middle, Last)

Robert Devilbiss

18. Mother's Name (First, Middle, Maiden Surname)

Marie Nickoles

19e. Informant's Name/Relationship (Type, Print)

Martha Devilbiss, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3858 Littlestown Pike, Westminster, MD 21158

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Westminster Cemetery

Date

3/15/97

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

Katherine Pritts - Sweitzer

22. Name and Address of Facility

Pritts Funeral Home

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

FATTY LIVER

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☒ Pending investigation 6 ☐ Could not be determined28e. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09297

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CANDICE LYNN DENNING

2. Date of Death

MARCH 11 1997

3. Time of Death

3:11 PM

4a. Facility Name (If not institution, give street and number)

5636 HODGES ROAD

4b. City, Town, or Location of Death

SYKESVILLE

4c. County of Death

CARROLL

Funeral  
Director

5. Social Security Number

215-60-6990

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 6, 1953

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

SYKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5636 HODGES ROAD

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WAYNE HERMANN

18. Mother's Name (First, Middle, Maiden Surname)

MIRIAM NALL

19a. Informant's Name/Relationship (Type, Print)

PETER D. DENNING/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5636 HODGES ROAD SYKESVILLE, MARYLAND 21784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CARROLL CREMATION, INC.

Date

3/13/97

20c. Location - City or Town, State

HAMPSTEAD, MARYLAND

21. Signature of Funeral Service Licensee

Jeffrey N. Zumbun

22. Name and Address of Facility

JEFFREY N. ZUMBUN FUNERAL HOME

6028 SYKESVILLE ROAD SYKESVILLE, MARYLAND 21784

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC MELANOMA.

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey N. Zumbun

29c. License number

A18320

29d. Date signed (Month, Day, Year)

3/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John FETTER M.D. Johns Hopkins Oncology Center

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

John A. Anderson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09298

Reg. No.

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Anna DENT</b>  |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>13</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2:36pm</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctor's Community Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-26-4020</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 7, 1923</b>                                     |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Landover</b>   |  |
| To Be Completed by Funeral Director   | 10e. State<br><b>MD</b>   |  | 10f. Zip Code<br><b>20785</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                      |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas G. Dowling</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna L. Wallace</b>   |  |  |  |
|   | 19. Informant's Name/Relationship (Type, Print)<br><b>Anna L. Broglio</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7110 Greeley Road, Landover, Maryland 20785</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | 20c. Date<br><b>03/17/97</b>  |  | 20d. Location - City or Town, State<br><b>Suitland, Maryland</b>                               |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Claudette J. Gasch</b>  |  |   |  | 22. Name and Address of Facility<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Heart Failure</b><br>Due to (or as a consequence of):<br><b>b. Coronary heart disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>c. Ascites, Renal Failure</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>Two three months many years</b> |  |   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pericarditis, tricuspid and mitral insufficiency</b><br><b>Ascites, Renal Failure</b>  |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   |  |   |  |  |  |
| 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>             |   |  |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Frederick H. Wilhel</b><br><b>29c. License number</b><br><b>010220</b><br><b>29d. Date signed (Month, Day, Year)</b><br><b>3/13/97</b>  |   |  |   |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Frederick H. Wilhel 5801 Annapolis Road; Huntville, Maryland</b>   |   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 1997</b><br><b>32. Registrar's Signature</b><br><b>John Anderson-Rodell</b>  |   |  |   |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09299

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Rogers Evans

2. Date of Death

March 7 1997 2:05 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2805 Farris Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

5. Social Security Number

205 03 0527

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 11 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2805 Farris Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

No

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

No

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Bank Teller

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Earl Harry Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Ida Jane Mannear

19a. Informant's Name/Relationship (Type, Print)

Donna Jean Evans Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2805 Farris Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Fort Lincoln Cemetery March 11, 1997 Brentwood Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

b. Asthmatic Bronchitis

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D12015

29d. Date signed (Month, Day, Year)

3-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis Steinberg MD 6492 Landover Rd Landover MD 20785

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Richardson, May 1, 1911.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09300

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sadie Clara Fazenbaker

2. Date of Death

Month Day Year  
MARCH 13 1997

3. Time of Death

0420am

4e. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

218-64-9269

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 11, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Garrett

10c. City, Town or Location

Swanton,

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street end Number

2338 Bittering Road

10f. Zip Code

21561

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel VanSickle

18. Mother's Name (First, Middle, Maiden Surname)

Ella Uphold

19a. Informant's Name/Relationship (Type, Print)

Hazel R. O'Brien

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

4025 Bittering Road, Swanton, MD 21561

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Paul's Cem., Mar. 16, 1997

20c. Location - City or Town, State

Accident, MD

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A., P.O. Box 275,  
179 Miller Street, Grantsville, MD 2153623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. COMA

Due to (or as a consequence of):

b. Central Nervous System Bleeding/Spasm

Due to (or as a consequence of):

c. Disseminated Intravascular Coagulation

Due to (or as a consequence of):

d. Autoimmunity

Approximate  
Interval Between  
Onset and Death

2 Days

UNKNOWN

UNKNOWN

UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Stroke

- Thrombocytopenia

- renal insufficiency - Fall

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

  
ARNOLD VERA M.D., M.P.H.

29c. License number

D 41980

29d. Date signed (Month, Day, Year)

MARCH 14 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

VERA, ARNOLD, M.D. 925 BISHOP WELSH DRIVE CUMBERLAND, MD. 21502

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 18 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

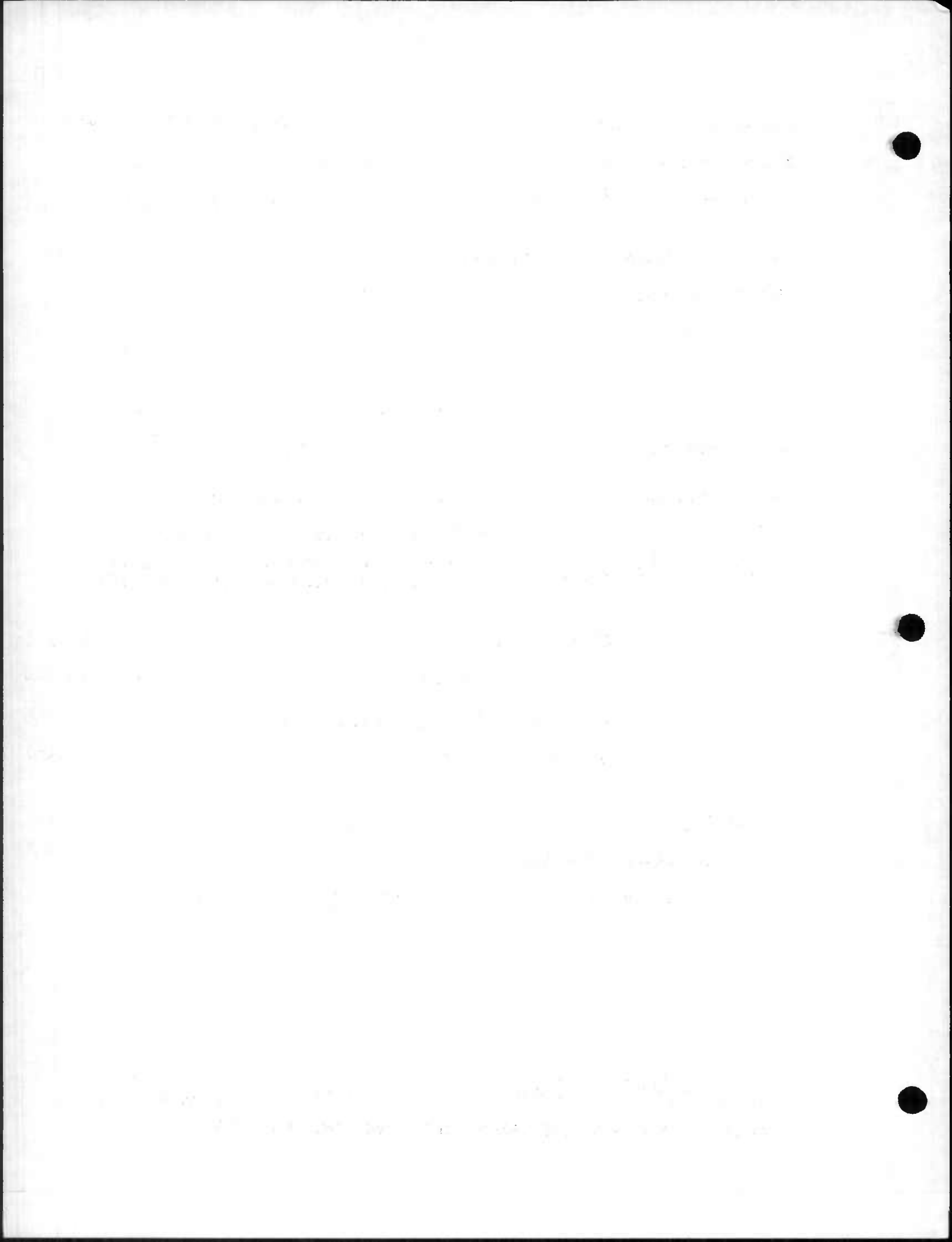
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 09301

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Margaret A. Fisher  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MAR 14 1997   |  | 3. TIME OF DEATH<br>8:00 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>202-38-9477  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>93 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept 5, 1903   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Goodwill Mennonite Home   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Grantsville  |  | 9c. COUNTY OF DEATH<br>Garrett  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br>PA  |  | 10b. COUNTY<br>Somerset  |  | 10c. CITY, TOWN OR LOCATION<br>Salisbury  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>103 Rear Grant Street   |  |  |  | 10f. ZIP CODE<br>15558  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>8 th  |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Chapman   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Catherine Trapp  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Eugene Fisher   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>172 S. Grant St., Box 432, Salisbury, PA 15558   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Michael's Cem. Mar 17, 97   |  | 20c. LOCATION — City or Town, State<br>West Salisbury, PA   |  | 20d. DATE<br>Mar 17, 97   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Eugene Fisher</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Newman Funeral Home, Inc.<br>101 S. Grant St., Salisbury, PA 15558  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>2 weeks<br>10 years |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal Failure.<br>Cerebrovascular disease.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James E Bertulmo</i>  |  |  |  | 29c. LICENSE NUMBER<br>D34079   |  | 29d. DATE SIGNED (Month, Day, Year)<br>MAR 14, 1997   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>James E Bertulmo Grantsville MD 21536  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 18 1997  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09302

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE MARIE FORGETTE

2. Date of Death

MARCH 15, 1997

3. Time of Death

1515

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

227 20 2244

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

March 8 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

St. Leonard

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6023 Maple Road

10f. Zip Code

20685

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Thomas Edison Trimble

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Southall

19a. Informant's Name/Relationship (Type, Print)

Paul P. Forgette- husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6023 Maple Rd. St. Leonard Maryland 20685

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Service

Date

March 16 1997

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

B. Brown

22. Name and Address of Facility

Rausch Funeral Home  
4405 Brookes Is. Rd. Port Republic Maryland 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Heart Disease

Due to (or as a consequence of):

Cardiac Arrhythmia -

Due to (or as a consequence of):

O15 Ant. septal

Due to (or as a consequence of):

Myocardial Infarction

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus -

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. P. Shah

29c. License number

D-22634

29d. Date signed (Month, Day, Year)

3/16/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mahesh P. Shah, M.D. 110 Hospital Road Prince Frederick Maryland 20678

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

John Davidson Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09303

|  |   |  |   |                                      |  |   |   |  |
|--|---|--|---|--------------------------------------|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LOCKIE MAE FORD</b>  |  |   |                                      | 2. Date of Death<br>Month Day Year<br><b>MARCH 16, 1997</b>  |   | 3. Time of Death<br><b>4:50 a.m.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>FORT WASHINGTON HOSPITAL</b>   |  |   |                                      | 4b. City, Town, or Location of Death<br><b>FORT WASHINGTON</b>   |   | 4c. County of Death<br><b>PRINCE GEORGE</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-86-1953</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 12, 1905</b>                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |  | 10a. State<br><b>Maryland</b>   |                                      | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Oxon Hill</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>5412 Virginia Ct.</b>  |                                      | 10f. Zip Code<br><b>20745</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>N/A</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |                                      | 16b. Kind of Business/Industry<br><b>Home</b>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>David Bolt</b>  |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Claricy Tolliver</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenneth L. Ford (Son)</b>  |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5412 Virginia Ct. Oxon Hill Maryland 20745</b>   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Halidon Cemetery</b>   |                                      | 20c. Date<br><b>March 21, 1997</b>   |   | 20d. Location - City or Town, State<br><b>Green Sulphur Springs West Virginia</b>           |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |                                      | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc.<br/>6633 Old Alexandria Ferry Rd Clinton, Md 20735</b>   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic renal failure</b><br>Due to (or as a consequence of):<br>b. <b>ASCVD</b><br>Due to (or as a consequence of):<br>c. <b>CHF</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                      |  |   |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                      |  |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                      |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                      |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |                                      |  |   |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      |  |   |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>NA</b>   |                                      | 28b. Time of Injury<br><b>NA</b> M <b>NA</b>   |   | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>   |  | 28d. Describe how injury occurred<br><b>NA</b>  |                                      |  |   |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>NA</b>   |  |   |                                      |  |   |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                      |  |   |   |  |
| 29b. Signature and title of certifier<br>  |   |  |   | 29c. License number<br><b>D45881</b> |  | 29d. Date signed (Month, Day, Year)<br><b>3/16/97</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>700 Old Line Center Waldorf MD 20602 #203</b>           |   |  |   |                                      |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>  |   |  |   | 32. Registrar's Signature<br>        |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09304

Amended # 10 g. P.G.C. 3-19-97 cr

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUAN GUSTAVO FUENTES

2. Date of Death

Month Day Year  
MAR 12 1997

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

216-27-0689

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 8, 1926

9. Birthplace (State or Foreign Country)

Guatemala

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5102 56th

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A. Guatemala

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☒ Yes 2 ☐ No Specify: Guatemalan

14. Race - American Indian,

Black, White, etc.  
Specify: Hispanic

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

2

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Shell Oil Company

17. Father's Name (First, Middle, Last)

Oswaldo de Leon

18. Mother's Name (First, Middle, Maiden Surname)

Clara Luisa Munchmeyer

19a. Informant's Name/Relationship (Type, Print)

John W. Wilson - Grandson In Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5701 Queens Chapel Road, Hyattsville, MD 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD Nat'l Memorial Park 03/12/97

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiopulmonary arrest

Approximate Interval Between Onset and Death

30 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke, Hypertension

Arteriosclerotic Heart Disease

Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

29c. License number

29d. Date signed (Month, Day, Year)

Dikwon.n.n

D-30927

3/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

OKI KWON, M.D. 1104 Spring Street #201, Silver Spring, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Anderson-Roberts

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



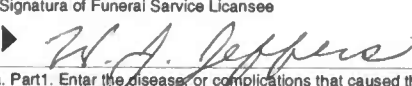
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09305

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Gwendolyn Genora Farges</b>  |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>10</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>08:48</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical System</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore City</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>239-31-5745</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>32</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>12-05-64</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>VA.</b>  |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore Co.</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>2652 Lauretta Avenue</b>  |  | 10f. Zip Code<br><b>USA</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>+2</b>            |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Private Industry</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Joe Louis Farges</b>  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella Harris</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Glenda Russell</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>233 Willie Pace Rd. Burlington, NC 27217</b>  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bibleway Church Cemetry</b>   |  | 20c. Location - City or Town, State<br><b>03/15/97 Milton, NC</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Frazier's Funeral Home, Inc.<br/>389 R.I. Ave., NW Washington, D.C. 20001</b>   |  |   |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Hypoxemia</b><br>Due to (or as a consequence of):<br>b. <b>Exsanguination diffusely from manipulated intraabdominal sites</b><br>Due to (or as a consequence of):<br>c. <b>Coagulopathy</b><br>Due to (or as a consequence of):<br>d. <b>Ruptured ovarian cyst / bleeding adnexal tissue</b> |  |  |  | Approximate Interval Between Onset and Death<br><br><b>1/2 hour</b><br><b>16 hours</b><br><b>18 hours</b><br><b>24 hours</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>28d. Describe how Injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b> |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br> <b>Resident MD</b>  |  |   |  |
|   | 29c. License number<br><b>PO9777</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 10, 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Tason Spurling MD Dept of Surgery 22 S. Greene Street Baltimore, MD 21201</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |





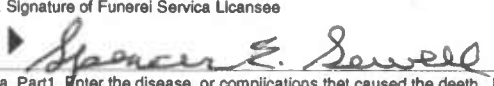
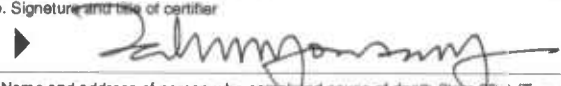
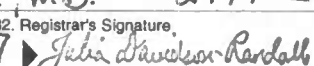
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State of Maryland / Department of Health and Mental Hygiene

97 09306

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marian Greene</b>                                 |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>8</b> Year <b>1997</b> |  | 3. Time of Death<br><b>7:00P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1828 Parkers Creek Road</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Port Republic</b>         |  | 4c. County of Death<br><b>Calvert</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-24-5335</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 1, 1925</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>  |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>Port Republic</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1828 Parkers Creek Road</b>  |  |   |  | 10f. Zip Code<br><b>20676</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printer</b>  |  |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>                                    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilmer Saunders</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hibernia Bolding</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dukette Rutherford/Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1822 Parkers Creek Rd. Port Republic, MD 20676</b>                                       |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Southern Mem. Gardens</b>  |  | Date<br><b>3/13/97</b>   |  | 20c. Location - City or Town, State<br><b>Dunkirk, MD</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Sewell Funeral Home<br/>1451 Dares Beach Road Prince Frederick, MD 20678</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Carcinoma.</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> Due to (or as a consequence of): |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>4 weeks</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D27189</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/12/97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Zahir Yousof, MD. 2417 Solomons Island Rd. Huntingtown, Md. 20639</b>  |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration. The President states that he is committed to the principles of liberty and justice for all, and that he will work to maintain the Union. He also mentions the issue of slavery, which was a major point of contention at the time.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It provides a detailed account of the financial state of the country. The report mentions the national debt, which had increased significantly since the end of the Civil War. It also discusses the various sources of revenue, such as taxes and customs duties, and the government's efforts to manage the budget.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1861. It provides information about the land and natural resources of the country. The report mentions the various territories and states, and the government's policies regarding land ownership and resource management. It also discusses the progress of the various departments, such as the Bureau of Land Management and the Geological Survey.

4. The fourth part of the document is a report from the Secretary of the Navy, dated January 1, 1861. It provides information about the state of the navy and the various ships and vessels. The report mentions the progress of the various departments, such as the Bureau of Naval Affairs and the Navy Yard. It also discusses the government's efforts to modernize the navy and improve its capabilities.

5. The fifth part of the document is a report from the Secretary of the War, dated January 1, 1861. It provides information about the state of the army and the various regiments and battalions. The report mentions the progress of the various departments, such as the War Department and the Army Medical Department. It also discusses the government's efforts to improve the army and its readiness for war.

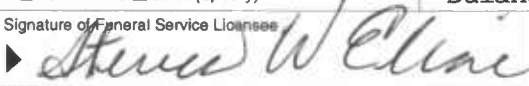
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09307

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |   |  |   |  |
|---|---|---|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Esther Thelma Garrity</b>  |   |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> , Year <b>1997</b>  |   | 3. Time of Death<br><b>9:30 PM</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>17217 Forreston Road</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Upperco</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-10-6305</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jul 26, 1914</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
|   | Usual Residence of Decedent   |   |   |   |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Upperco</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>17217 Forreston Road</b>   |   |   |   | 10f. Zip Code<br><b>21155</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Bernard Paul Federline, Sr.</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Middleton Phelps</b>  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bernadette Jordan, daughter</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17217 Forreston Rd, Upperco, MD 21155</b>  |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem Gard</b>  |   | Date<br><b>3/15</b>  |   | 20c. Location - City or Town, State<br><b>Timonium, MD</b>                                     |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>Eline Funeral Home</b><br><b>934 S Main St, Hampstead, Md 21074</b>   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pulmonary fibrosis</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>2 yrs.</b> |   |   |   |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>NA</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Spinal stenosis</b><br><b>HBP</b><br><b>Peripheral neuropathy</b>  |   |   |   |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br> MD   |   | 29c. License number<br><b>D18822</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/13/97</b>                                       |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>R. HABERSAT 214 MT CARMEL RD PARKTON, MD 21120</b> |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 17 1997</b>   |   | 32. Registrar's Signature<br>  |   |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09308

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |   |  |  |   |
|---|---|--|---|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Kenneth Eugene Grimes   |  |   |   | 2. Date of Death<br>Month Day Year<br>March 14, 1997   |   | 3. Time of Death<br>6:45AM   |  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>College View Center   |  |   |   | 4b. City, Town, or Location of Death<br>Frederick  |   | 4c. County of Death<br>Frederick   |  |   |
| Funeral<br>Director   | 5. Social Security Number<br>213-10-2088  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>88 Yrs.   | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Dec 18, 1908 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |   |
|   | Usual Residence of Decedent   |  |   |   |  |   |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Frederick  |   | 10c. City, Town or Location<br>Woodsboro   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |
|   | 10e. Street and Number<br>100 S. Main St.   |  |   |   | 10f. Zip Code<br>21798   |   | 10g. Citizen of What Country?<br>U.S.A.,   |  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Dynamite Technician   |   | 16b. Kind of Business/Industry<br>Quarry   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br>Sheridan Scott Grimes  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Blanche C. Potts  |   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Ruth L. Grimes/wife   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>100 S. Main St. Woodsboro, Md. 21798  |   |  |  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oak Hill Cemetery   |   | Date<br>3/16/97  |   | 20c. Location - City or Town, State<br>Legore, Maryland  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Catharine O. Hartzler</i>   |  |   |   | 22. Name and Address of Facility<br>Hartzler Funeral Home<br>Woodsboro, Md. 21798  |   |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Alzheimer's Disease</i><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |  |  | Approximate Interval Between Onset and Death<br>4 yrs |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Emphysema</i>  |  |   |   |  |   |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |  |   |  |  |   |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |   |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                     |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |   |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |  |  |   |
| 29b. Signature and title of certifier<br><i>Gene F. Ashe</i>  |   |  |   | 29c. License number<br>D31058                       |  | 29d. Date signed (Month, Day, Year)<br>3/14/97      |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gene F. Ashe Woodsboro Medical Center Woodsboro, MD |   |  |   |   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>MAR 17 1997  |   |  |   | 32. Registrar's Signature<br><i>John A. Randall</i> |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09309

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROXIE GADDY</b>  |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>09</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>04:28 P.M.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>245-54-8357</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>May 6, 1912</b>   | 9. Birthplace (State or Foreign Country)<br><b>Marrietta, N.C.</b>   |  |
|  | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>Upper Marlboro</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>12508 Cynthia Court</b>   |  |
|  | 10f. Zip Code<br><b>20774</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired Farmer</b>   |  | 16b. Kind of Business/Industry<br><b>Private</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Gaily Ford</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrilla Williams</b>  |  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Sadie McEachin - Daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12508 Cynthia Court, Upper Marlboro, MD 20774</b>  |  |  |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gaddy Family Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>3/15/97 Fairmont, N. C.</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>   |  |  |  | 22. Name and Address of Facility<br><b>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N. E., Washington, D. C.</b>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>e. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death   |  |  |  |
|  | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>               |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b>   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br><b>Deputy Medical Examiner</b>  |  | 29c. License number<br><b>033954</b>   |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>MARCH 10, 1997</b>   |   |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARIO F. GOLUB, JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 12 1997</b>  |   |  |  | 32. Registrar's Signature<br><b>John D. [Signature]</b>  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09310

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leado Grear, Jr.

2. Date of Death  
Month Day Year

MAR 11 1997

3. Time of Death

7:35AM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-44-2676

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-9-1933

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2207 Coleridge Drive

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Station Manager

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Leado Grear, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Bernice Stroman

19a. Informant's Name/Relationship (Type, Print)

Gladys Grear/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2207 Coleridge Dr., Silver Spring, Md. 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

3/15/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Shelton W. Hackett

22. Name and Address of Facility

Hackett's Funeral Chapel, Inc.  
814- Upshur Street, N.W.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 YRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCITIS.

Due to (or as a consequence of):

1 YR

c. CARDIOMYOPATHY

Due to (or as a consequence of):

d. LYMPHOMA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

INSULIN DEPENDENT DIABETES MELLITUS

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chamberlain PHYSICIAN

29c. License number

D40804 MD

29d. Date signed (Month, Day, Year)

03/11/1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kewal Sharma, M.D. 10620 Georgia Ave., Silver Spring, Md. 20902

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John Stedman Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09311

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>JOSEPH PARRAN HILL   |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 13, 1997 |   |  | 3. Time of Death<br>8:01 pm  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PHYSICIANS MEMORIAL HOSPITAL   |  |  | 4b. City, Town, or Location of Death<br>LA PLATA     |   |  | 4c. County of Death<br>CHARLES   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>219-16-0084   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>73 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Dec 7, 1923                                   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent  |  |  |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland   |  | 10b. County<br>Charles   |  | 10c. City, Town or Location<br>Bryantown  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>5613 Huckleberry Drive   |  |  |  | 10f. Zip Code<br>20617  |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>XX <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WW II<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th College (1-4 or 5+) 8th   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Concrete Mixer Operator  |  |  | 16b. Kind of Business/Industry<br>Howart Concrete Company        |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Samuel Aubrey Hill  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Edith Pearl Jenkins  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Norma J. Rowe  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5613 Huckleberry Drive, Bryantown, Md 20617  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Epiphany Church Cemetery  |  |  | 20c. Location - City or Town, State<br>Forestville, Maryland     |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Charles L. Belanger   |  |  |  | 22. Name and Address of Facility<br>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cardiac Arrhythmia<br>Due to (or as a consequence of):<br>b. Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |  |  |
|   | 23c. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |  |  |  |  |
|   | 23d. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |   |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>Deputy Medical Examiner   |  |  |  | 29c. License number<br>D-46419  |  |  | 29d. Date signed (Month, Day, Year)<br>3/14/97                   |  |  |
| State<br>Registrar                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CHARLENE LETCHFORD, MD, 700 OLD LINE CENTER WALDORF, MD 20602  |  |  |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>MAR 1 8 1997  |  |  |  | 32. Registrar's Signature<br>John Andrew Randall  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used in the study.

3. The third part is a discussion of the results of the study.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of figures and tables.

6. The sixth part is a list of appendices.

7. The seventh part is a list of footnotes.

8. The eighth part is a list of symbols and abbreviations.

9. The ninth part is a list of acknowledgments.

10. The tenth part is a list of references.

11. The eleventh part is a list of figures and tables.

12. The twelfth part is a list of appendices.

13. The thirteenth part is a list of footnotes.

14. The fourteenth part is a list of symbols and abbreviations.

15. The fifteenth part is a list of acknowledgments.

16. The sixteenth part is a list of references.

17. The seventeenth part is a list of figures and tables.

18. The eighteenth part is a list of appendices.

19. The nineteenth part is a list of footnotes.

20. The twentieth part is a list of symbols and abbreviations.

21. The twenty-first part is a list of acknowledgments.

22. The twenty-second part is a list of references.

23. The twenty-third part is a list of figures and tables.

24. The twenty-fourth part is a list of appendices.

25. The twenty-fifth part is a list of footnotes.

26. The twenty-sixth part is a list of symbols and abbreviations.

27. The twenty-seventh part is a list of acknowledgments.

28. The twenty-eighth part is a list of references.

29. The twenty-ninth part is a list of figures and tables.

30. The thirtieth part is a list of appendices.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09312

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine McAllister Herndon

2. Date of Death

March 10, 1997

3. Time of Death

2:33 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

579-46-9381

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/2/37

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1239 Nalley Road

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Computer Specialist

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

William Robert McAllister

18. Mother's Name (First, Middle, Maiden Surname)

Alonia McNeil

19a. Informant's Name/Relationship (Type, Print)

Frederick H. Herndon/Husband Same as # 10 above

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Mem. Park 3/15/97

Date

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Darryl H. Pratt

22. Name and Address of Facility

H.S. Washington & Sons, Inc.  
4925 Burroughs Ave., N.E.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Cardiopulmonary arrest

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

5 hours

3 minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

DR. NORMAN MC KOY

29c. License number

D 35947

29d. Date signed (Month, Day, Year)

3/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

10274 CORK ARLON AVE #202 dublin caldwell ans. 20721

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09313

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |  |  |  |
|--|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Harry A. Hegarty</b>                                  |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>10</b> Year <b>1997</b>       |  | 3. Time of Death<br><b>3:14 A.M.</b>   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Larkin - Chase Nursing Home</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Bowie</b>                        |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577 30 0009</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 6, 1913</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bowie</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>12612 Buckingham Drive</b>  |  |   |  | 10f. Zip Code<br><b>20715</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>30-33</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>  |   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry A. Hegarty</b>   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Hillery</b> |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean M. Hegarty Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12612 Buckingham Drive Bowie Maryland 20715</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Cemetery March 13, 1997 Bowie Maryland</b>  |  |   | Date  |  | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><b>Shannon W. Ramirez</b>   |  |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Maryland 20715</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>supra nuclear puls</b><br>Due to (or as a consequence of):<br>b. <b>prostate cancer</b><br>Due to (or as a consequence of):<br>c. <b>Renal insufficiency</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>One year</b><br><b>4 year</b><br><b>2 months</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b>   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |  |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Robert F. Fahn M.D.</b>  |  |   |  | 29c. License number<br><b>D43446</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3. 11. 97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ROINTAN FARAH FAR 4000 Mitchellville road B216 Bowie MD 20716</b>   |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>John Michael Randall</b>  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. It. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09314

AMENDED # 5. P.G.C. 3-18-97 cr

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Louise Alice HYSAN

2. Date of Death

Month Day Year  
March 6, 1997

3. Time of Death

2:10AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

215-09-0677

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 3, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7414 Longbranch Drive

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Payroll Clerk

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

Solomon Levi Myers

18. Mother's Name (First, Middle, Maiden Surname)

Laura May Manahan

19a. Informant's Name/Relationship (Type, Print)

Georgette Wagner - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7414 Longbranch Drive, New Carrollton, MD 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

03/10/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Henry S. Searl

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Immediate.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes type 2, Coagulopathy with  
circulating anticoagulant,  
Bladder Polyps.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stuart Turkewitz MD

29c. License number

D31001

29d. Date signed (Month, Day, Year)

3/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart Turkewitz, M.D.

2500 Greenway Ctr. Dr. #430  
Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

97 09315

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Leroy Hamilton

2. Date of Death

Month Day Year  
March 7, 1997

3. Time of Death

12:15 am

4a. Facility Name (If not institution, give street and number)

Greenbelt Nursing Center

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-22-6609

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 23, 1924

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7010 Greenbelt Road

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Joseph C. Hamilton

18. Mother's Name (First, Middle, Maiden Surname)

Esther E. Herbaugh

19a. Informant's Name/Relationship (Type, Print)

Mabel H. Yoho - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27720 Ridge Road, Damascus, Maryland 20872

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

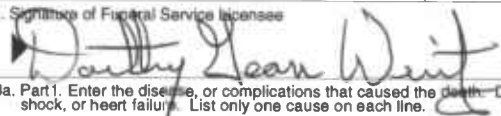
Metropolitan Crematory 03/07/97

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service licensee



22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Acute respiratory failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

minutes

b.

Congestive heart failure

Due to (or as a consequence of):

yrs

c.

metastatic Carcinoma prostate

Due to (or as a consequence of):

yrs

d.

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute or chronic renal insufficiency,  
Anaemia, Coronary artery disease  
Chronic deep vein thrombosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



Ravinder K. Rustagi MD

29c. License number

D24720

29d. Date signed (Month, Day, Year)

March 7, 1997

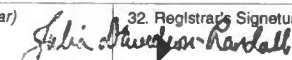
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravinder K. Rustagi, M.D. 6132 Landover Road, Cheverly, Maryland 20785-1022

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09316

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>IVAN HAYES</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>3</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2:44 pm</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>234 46 3305</b>  |  | 6. Sex<br><b>MALE</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 11 1931</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  | 10a. State<br><b>Ohio</b>   |  | 10b. County<br><b>Summit</b>   |  | 10c. City, Town or Location<br><b>Norton</b>  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>2759 Shellhart Road</b>   |  |   |  | 10f. Zip Code<br><b>44203</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>51-55</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>12</b> <b>College (1-4 or 5+)</b>   |  |   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>   |  | 16b. Kind of Business/Industry<br><b>Akron Standard Mold</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Glenn Hayes</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Doris Bonnell</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)<br><b>Joan H. Hayes</b> <b>Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2759 Shellhart Rd. Norton Ohio 44203</b>   |  |   |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greene Cemetery-March 7, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Mannington West Virginia</b>   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.</b><br><b>16000 Annapolis Rd. Bowie Md. 20715</b> |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.</b><br><b>16000 Annapolis Rd. Bowie Md. 20715</b>  |  |   |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death)</b><br><b>a. Acute Myocardial Infarction</b><br><b>b. Coronary Artery Disease</b><br><b>c. </b><br><b>d. </b>                                 |  |   |  | Approximate Interval Between Onset and Death<br><b>14 hrs</b><br><b>16 years</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><b>Arvind M. Mehta MD</b>   |  |   |  |
|   | 29c. License number<br><b>027366</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>3/4/97</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARVIND M. MEHTA 7100 Baltimore Ave # 509, College Park MD 20740</b>   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 11 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br>  |  |   |  | 33. Registrar's Signature<br>  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09317

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Hunnicutt</b>                                    |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>4</b> Year <b>1997</b> |  | 3. Time of Death<br><b>7:16 AM</b>                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>             |  | 4c. County of Death<br><b>Frederick</b>               |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-44-7328</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>6/22/35</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Wash DC</b>   |  | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>Montgomery</b>                                     |  | 10c. City, Town or Location<br><b>Rockville</b>       |  |
| Usual Residence of Decedent   |  |  |  |  |  |  |   |  |
| 10a. State<br><b>Md</b>   |  |  | 10b. County<br><b>Montgomery</b>   |  |  | 10c. City, Town or Location<br><b>Rockville</b>  |   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  | 10e. Street and Number<br><b>801 Duke St</b>   |  |  | 10f. Zip Code<br><b>20850</b>  |   |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                               |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                     |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Policeman</b>   |  |  | 16b. Kind of Business/Industry<br><b>Police Dept</b>   |  |  | 17. Father's Name (First, Middle, Last)<br><b>Lloyd Hunnicutt</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Luskey</b>   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine Klash</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10712 Lombardy Rd Silver Spring Md 20901</b> |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Howard U. Med School</b>  |  |  | 20c. Location - City or Town, State<br><b>3/5/97 Wash DC</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Royce P. Mason</b>  |  |  | 22. Name and Address of Facility<br><b>AAMAN FUNERAL SERVICE<br/>1601 Kenilworth Ave NE Wash DC 20019</b>  |  |  |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pulmonary embolus (probable)</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |  |  |   |  |
| Approximate Interval Between Onset and Death<br><b>3 hrs</b>  |  |  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b><br><b>DIABETES MELLITUS</b><br><b>CARDIO-VASCULAR DISEASE</b>  |  |  |  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day Year)  |  |  | 28b. Time of Injury<br><b>M</b>  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  | 28d. Describe how injury occurred  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Gary Smith M.D. VPH</b>   |  |  | 29c. License number<br><b>D10587</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/6/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>GEORGE I. SMITH JR M.D</b><br><b>400 W. 7th St.; Frederick, MD 21701</b>   |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 11 1997</b>   |  |  |  |  |  |  |   |  |
| 32. Registrar's Signature<br><b>John D. Randall</b>   |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09318

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TONYA

RENEE

HARRIS

2. Date of Death

Month

Day

Year

March

10

1997

3. Time of Death

4:30 P.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE CARE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

216-86-5876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

31

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 4, 1965

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

BELTSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4709 PRINCE GEORGES AVENUE

10f. Zip Code

20705

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10TH

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNEMPLOYED

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

ZOLLY COMMER

18. Mother's Name (First, Middle, Maiden Surname)

DORETHA HARRIS

19a. Informant's Name/Relationship (Type, Print)

JOHNNIE EDWARDS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7603 NORMANDY ROAD LANDOVER MARYLAND 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

3/14/97

20c. Location - City or Town, State

BLADENSBURG, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

AUSTIN ROYSTER FUNERAL HOME±  
3821 14TH ST. N.W. WASH DC. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

15504

29d. Date signed (Month, Day, Year)

3. 10 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD., TOWSON, MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09319

|  |   |  |  |  |  |  |   |  |
|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>VERDELL HODGE</b>  |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>09</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>10:15 A.M.</b><br><b>FOUND</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6603 LIVINGSTON ROAD</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>OXON HILL</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>455-52-2428</b>   |  | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 20, 1935</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Texas</b>  |  | 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>Oxon Hill</b>   |  |
| To Be Completed by<br>Funeral Director                               | 10a. Street and Number<br><b>6603 Livingston Road</b>   |  | 10f. Zip Code<br><b>20745</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>Ret. 1989</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>U. S. Army</b>   |  | 16b. Kind of Business/Industry<br><b>Military</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Mack Welton Hodge</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elvessia Carey</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Hodge/ wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6603 Livingston Rd. Oxon Hill, Md. 20745</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem.</b>   |  | 20c. Location - City or Town, State<br><b>3/19/97 Arlington, Virginia</b>  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>George P. Kalas</b>   |  |  |  | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home</b><br><b>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|  |   |  |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Deputy Medical Examiner</b><br><b>D 33954</b>  |  | 29c. License number<br><b>D 33954</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 09, 1997</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARIO F. GOLLE JR. M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>  |  |  |  |  |  |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAR 12 1997</b>   |  | 32. Registrar's Signature<br><b>John Andrew Randall</b>  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09320

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Leon Marcus HOUSTON

2. Date of Death

Month Day Year  
March 12, 1997

3. Time of Death

12:55 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

449-16-3888

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08-09-1916

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9024 Volta Street

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 9/17/42 to 9/10/45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Leon O. Houston

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Thomas

19a. Informant's Name/Relationship (Type, Print)

Rita L. Houston/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12317 Chesterton Dr., Upper Marlboro, MD 20772

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

03/18/1997

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory failure  
Due to (or as a consequence of):

Approximate interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart failure  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Dementia

w/o Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Michael S. Siph MD

29c. License number

D45660

29d. Date signed (Month, Day, Year)

3-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3060 Mitchellville Rd, Bowie MD 20716

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09321

## Certificate of Death

Reg. No.

|   |   |   |   |   |   |   |  |  |  |
|---|---|---|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Beryl Maude Hibbert   |   |   |   | 2. Date of Death<br>Month Day Year<br>03-10-97  |   | 3. Time of Death<br>7:15 AM  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>12712 Princeleigh Street  |   |   |   | 4b. City, Town, or Location of Death<br>Upper Marlboro  |   | 4c. County of Death<br>Prince George's   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>573-86-7129  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>74 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>09-09-22  | 9. Birthplace (State or Foreign Country)<br>Jamaica, W.I.  |  |
|   | Usual Residence of Decedent   |   |   |   |   |   |  |  |  |
| To Be Completed by Funeral Director   | 10e. State<br>Maryland  |   | 10b. County<br>Prince George's  |   | 10c. City, Town or Location<br>Upper Marlboro   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>12712 Princeleigh Street  |   |   |   | 10f. Zip Code<br>20774  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Home Attendant                           |   |   | 16b. Kind of Business/Industry<br>Private   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Josephia Reid  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jemima Clark   |   |  |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br>Coreli Housen / Daughter  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12712 Princeleigh Street Upper Marlboro, MD 20774  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery  |   | 20c. Location - City or Town, State<br>Brentwood, Maryland  |   | 20d. Date<br>3/13/97   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Nancy A. Perentis  |   |   |   | 22. Name and Address of Facility<br>J.B. Jenkins Funeral Home<br>7474 Landover Road Landover, MD 20785  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Papillary carcinoma of abdominal cavity 8 months<br>Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |   |   |   |  |  | Approximate Interval Between Onset and Death |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|   |   |   |   |   |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |  |  |
|   |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>Patrick Brown MD   |   | 29c. License number<br>D41728             |   | 29d. Date signed (Month, Day, Year)<br>3/10/97  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>110 Irving ST. N.W. Suite 3A-3 Washington D.C. 20010  |   |   |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 13 1997  |   | 32. Registrar's Signature<br>John Andrew Ricketts   |   |   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The few requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 09322

Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |   |  |
|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br>Jackie Allen Jennings, Sr.  |   |   | 2. Date of Death<br>Month Day Year<br>March 13, 1997   |  | 3. Time of Death<br>3:40 p.m.  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Harford Memorial Hospital   |   |   | 4b. City, Town, or Location of Death<br>Havre de Grace   |  | 4c. County of Death<br>Harford   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>162-32-7134  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>54 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>May 29, 1942  | 9. Birthplace (State or Foreign Country)<br>West Virginia   |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  | 10b. County<br>Cecil  | 10c. City, Town or Location<br>Perryville   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br>700C Carter Court, Richmond Hills   |   |   | 10f. Zip Code<br>21903   |  | 10g. Citizen of What Country?<br>U.S.A.  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Ten Years<br>Collage (1-4 or 5+) -----   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Security Guard                       |  | 16b. Kind of Business/Industry<br>Globe Security Wilmington, Delaware  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Archie Allen Jennings  |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br>Nina Jean Reynolds  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mary F. Jennings (Wife)   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>110 South Main Street, North East, Maryland 21901 |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>North East Methodist Cemetery   |  | 20c. Location - City or Town, State<br>North East, Maryland  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Thomas M. Patterson</i>   |   | 22. Name and Address of Facility<br>Lee A. Patterson & Son Funeral Home<br>Perryville, Maryland 21903-0188  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Sepsis</i><br>Due to (or as a consequence of):<br>b. <i>Colonic infarction</i><br>Due to (or as a consequence of):<br>c. <i>Neurotizing enterocolitis</i><br>Due to (or as a consequence of):<br>d.<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br>7<br>7<br>7  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i>   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how Injury occurred  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>John Paul M.D.</i>  |   | 29c. License number<br>D19626  | 29d. Date signed (Month, Day, Year)<br>3/15/97   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Chan J Park, MD 669 Revolution St, Havre de Grace MD 21078   |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 17 1997   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09323

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hester Louise Johnson

2. Date of Death  
Month Day Year

March 11 1997 1150 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

LaPlata Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

114-26-1156

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug. 18, 1918

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

New York

10b. County

10c. City, Town or Location

Brooklyn

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

315 Sutter Avenue

10f. Zip Code

11212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.  
Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Someone Else's  
Home

17. Father's Name (First, Middle, Last)

Guy Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Louise Jefferson

19a. Informant's Name/Relationship (Type, Print)

Warren Taylor/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 152 Lusby, MD 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. John UM Chr. Cem.

Date

3/17/97

20c. Location - City or Town, State

Lusby, MD

21. Signature of Funeral Service Licensee

Spencer E. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. CANCER OF THE STOMACH

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Congestive HEART FAILURE

DEMENTIA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Atulya Attending

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

MARCH 11 - 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVINKUMAR J PATEL MD 603 POST OFFICE RD #207 WILDFORD MD 20602

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09324

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILTON RAPHAEL JONES

2. Date of Death

Feb 27 1997 10:15 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2105 Hildarose Drive, Apt. 101

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-20-3231

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 29, 1924

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2105 Hildarose Drive, Apt. 101

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Chauffeur &amp; Messenger

16b. Kind of Business/Industry

National Geographic  
Society

17. Father's Name (First, Middle, Last)

William

Jones

18. Mother's Name (First, Middle, Maiden Surname)

Jelener

Hood

19a. Informant's Name/Relationship (Type, Print)

William Alonzo Jones (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2015 Georgian Woods Place, Wheaton, Maryland 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

March 6, 1997

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

▶ Bonnie E. Jones III

22. Name and Address of Facility

Latney's Funeral Home, Inc.  
3831 Georgia Avenue, N.W.; Washington, D.C. 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Due to (or as a consequence of):

Gastrointestinal Hemorrhage

Approximate  
Interval Between  
Onset and Death

24 hrs.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

Coronary of liver

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ John Tauber MD

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Feb. 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauber 8218 Wisconsin Ave Bethesda

31. Date filed (Month, Day, Year)

MAR 10 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09325

|  |   |  |   |   |  |  |  |   |                                   |  |
|--|---|--|---|---|--|--|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Leola Johnson</i>                              |  |   |   | 2. Date of Death<br>Month <i>3</i> Day <i>9</i> Year <i>1997</i>   |  | 3. Time of Death<br><i>5:10AM</i>  |   |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Mariner Nursing Home</i> |  |   |   | 4b. City, Town, or Location of Death<br><i>Bethesda</i>  |  | 4c. County of Death<br><i>Montgomery</i>   |   |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>579-44-3786</i>   |  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>85</i> Yrs.   |  | 6. Date of Birth (Month, Day, Year)<br><i>9/30/11</i>  |   |                                   |  |
|  | 10a. State  |  | 10b. County   |   | 10c. City, Town or Location<br><i>Washington, D.C.</i>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |                                   |  |
| 10e. Street and Number<br><i>4629 Hannah Place, S.E.</i>   |   |  |   | 10f. Zip Code<br><i>20020</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |   |                                   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                        |   |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>Unk.</i> College (1-4 or 5+)   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Dietitian</i>                     |  | 16b. Kind of Business/Industry<br><i>Food</i>  |  |   |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><i>John Henry Moody</i>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Alice UNKNOWN</i>   |  |  |  |   |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Lavern L. Johnson, Son</i>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4629 Hannah Place, S.E. Wash., D.C. 20020</i> |  |  |  |   |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Maryland Nat. Mem.</i>   |   | Date<br><i>3/14/97</i>   |  | 20c. Location - City or Town, State<br><i>Laurel, MD</i>                                       |   |                                   |  |
| 21. Signature of Funeral Service Licensee<br><i>William O. Ables</i>   |   |  |   | 22. Name and Address of Facility<br><i>Hall Brothers Funeral Home<br/>621 Florida Avenue, N.W. Wash., D.C.</i>                                    |  |  |  |   |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Atherosclerosis</i><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |   |   |  |  |  | Approximate interval Between Onset and Death<br><i>year</i>   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Parkinson's Disease</i><br><i>Anemia</i>  |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |                                   |  |
|  |   |  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   | 28d. Describe how Injury occurred |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  | 29b. Signature and title of certifier<br><i>John Ables MD</i>   |   |  | 29c. License number<br><i>020316</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>3/11/97</i>   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Dr. Schallman MD 5410 Old Georgetown Rd Bethesda, MD</i>  |   |  |   |   |  |  |  |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 11 1997</i>  |   |  | 32. Registrar's Signature<br><i>John Ables</i>  |   |  |  |  |   |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09326

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN

JONES

2. Date of Death

Month Day Year  
MARCH 9, 1997

3. Time of Death

3:55 am

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

066-54-6413

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 5, 1961

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Florida

10b. County

Hillsboro

10c. City, Town or Location

Tampa

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4514 West Knollwood Street

10f. Zip Code

32614

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
3+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Flight Attendant

16b. Kind of Business/Industry

Airlines

17. Father's Name (First, Middle, Last)

Kenneth Charles Jones

18. Mother's Name (First, Middle, Maiden Surname)

Helen Bass

19a. Informant's Name/Relationship (Type, Print)

Helen Jones/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1801 Chapel Tree Circle, Brandon, Florida 33511

20a. Method of Disposition

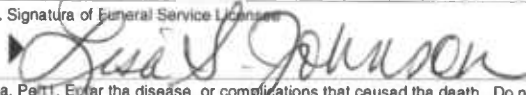
1 ☒ Burial ☐ Cremation ☐ Removal from State  
4 ☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garden of Memories Cemetery 3/14/97 Tampa, Florida

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Curry & Roel Garden of Memories Chapel  
4207 East Lake Avenue, Tampa, Florida 3361023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. ACUTE RESPIRATORY DISTRESS SYNDROME 2 WEEKS  
Due to (or as a consequence of):b. AUTOLOGOUS BONE MARROW TRANSPLANT 29 DAYS  
Due to (or as a consequence of):c. LYMPHOMA 6 MONTHS  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural ☐ Pending  
investigation  
2 ☐ Accident ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

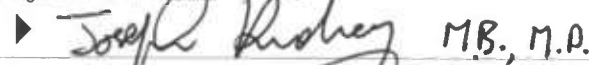
(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 M.B., M.A.

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

MARCH 9<sup>th</sup> 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 NTH. WOLFE SC 21287

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09327

Item: 5 per Informant G-746 4/1/97 reb

Certificate of Death

Reg. No.

|  |  |   |   |  |   |   |  |  |
|--|--|---|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES EUGENE JOHNSON</b>  |   |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>06</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>08:48 A.M.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |   | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-56-6120</b><br><b>577-61-6120</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>April 1, 1941</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D. C.</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |   | 10c. City, Town or Location<br><b>Landover</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>1604 Marblewood Avenue</b>   |  | 10f. Zip Code<br><b>20785</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Meter Installer</b>               |  | 16b. Kind of Business/Industry<br><b>D.P.W. Sewer &amp; Water Dept Government</b>   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Harold Carter, Sr.</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Thelma Johnson</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Verbel J. Johnson - Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1604 Marblewood Avenue, Landover, MD 20785</b>  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  | 20c. Date<br><b>3/12/97</b>   |   | 20d. Location - City or Town, State<br><b>Landover, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>  |   | 22. Name and Address of Facility<br><b>STEWART FUNERAL HOME, Inc.</b><br><b>4001 Benning Road, N.E., Washington, D. C.</b>                        |  |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b> Due to (or as a consequence of):<br><b>c. _____</b> Due to (or as a consequence of):<br><b>d. _____</b> |   |   |  |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No           |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>DEPUTY MEDICAL EXAMINER</b><br><b>D33954</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 06, 1997</b>                 |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARIO F. GOLUB JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>   |  |   |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 12 1997</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1991 SI RAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09328

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CONCHITA MARIE JACKSON

2. Date of Death

MARCH 6 1997

3. Time of Death

16:45

4a. Facility Name (If not institution, give street and number)

4312 28th Place Apartment # 3

4b. City, Town, or Location of Death

Mt. Rainer

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

578-72-8217

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 28, 1944

9. Birthplace (State or Foreign Country)

JAMAICA

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

MT. RAINER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4312 28th PLACE

10f. Zip Code

20712

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
BLACK15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

JOHN BARTON

18. Mother's Name (First, Middle, Maiden Surname)

LINDA WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

PETA-GAY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

470 TAYLOR ST NE # 22 WASHINGTON, D.C. 20017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Date

3/15/97

20c. Location - City or Town, State

SILVER SPRING, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHNSON &amp; JENKINS FUNERAL HOME

716 KENNEDY ST NW WDC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. BREAST CANCER

Due to (or as a consequence of):

6 YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

18561-DC

29d. Date signed (Month, Day, Year)

March 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID J. PERRY

110 IRVING STREET N.W. WDC 20010

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09329

## Certificate of Death

Reg. No.

|  |  |   |   |  |   |  |                              |  |
|--|--|---|---|--|---|--|------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Elmer Kline Kerns                                    |   |   |  | 2. Date of Death<br>Month: March Day: 10 Year: 1997       |  | 3. Time of Death<br>21:48    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Union Hospital of Cecil County |   |   |  | 4b. City, Town, or Location of Death<br>Elkton            |  | 4c. County of Death<br>Cecil |  |
| Funeral<br>Director  | 5. Social Security Number<br>232-26-0825   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>77 Yrs. | 8. Date of Birth (Month, Day, Year)<br>November 3, 1919  | 9. Birthplace (State or Foreign Country)<br>West Virginia |  |                              |  |
|  | Usual Residence of Decedent  |   |   |  |   |  |                              |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Cecil  |   | 10c. City, Town or Location<br>North East  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                              |  |
| 10e. Street and Number<br>435 West Old Philadelphia Road   |  |   |   | 10f. Zip Code<br>21901   |   | 10g. Citizen of What Country?<br>United States   |                              |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1942-45 US Army   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter/Builder Supervisor  |   | 16b. Kind of Business/Industry<br>U.S. Army/Government Testing Facility  |                              |  |
| 17. Father's Name (First, Middle, Last)<br>Pent Oliver Kerns   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sarah Robinson  |   |  |                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Celia B. Kerns / Spouse  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>435 W. Old Philadelphia Road, North East, MD 21901  |   |  |                              |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>North East Methodist Cem.   |   | 20c. Date<br>Mar. 14   |   | 20d. Location - City or Town, State<br>North East, Maryland  |                              |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>Crouch Funeral Home<br>127 South Main Street, North East, MD 21901   |   |  |                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Sepsis<br>Due to (or as a consequence of):<br>b. Cardiopulmonary collapse<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |   |  |                              |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                              |  |
|  |  |   |   |  |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                              |  |
|  |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |   |  |                              |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                              |  |
|  |  | 28d. Describe how Injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |                              |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |                              |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |   |  |                              |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br>D 32395   |   | 29d. Date signed (Month, Day, Year)<br>03-12-97  |                              |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Thomas E. Finucan 3 Mauldin Avenue North East, MD 21901  |  |   |   |  |   |  |                              |  |
| 31. Date filed (Month, Day, Year)<br>MAR 13 1997   |  |   |   | 32. Registrar's Signature<br>  |   |  |                              |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09330

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margie R. Kent

2. Date of Death

March 16 97

3. Time of Death

7 AM

4a. Facility Name (If not institution, give street and number)

Calvert Manor HealthCare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

202-18-9358

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07-12-13

9. Birthplace (State or Foreign Country)

Leola, PA

Usual Residence of Decedent

10a. State

PA

10b. County

Chester

10c. City, Town or Location

Nottingham

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

32 Park Rd.

10f. Zip Code

19362

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Herbert P. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Clara Hendrickson

19a. Informant's Name/Relationship (Type, Print)

Judith A. King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

32 Park Rd. Nottingham, PA 19362

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oxford Cemetery 3-19-1997 Oxford, PA 19363

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kevin S. Collins

22. Name and Address of Facility

Edward L. Collins Funeral Home, Inc.  
86 Pine St., Oxford, PA 19363

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DSCVD  
Due to (or as a consequence of):

5 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Phil R. Taylor, MD

29c. License number

0-11115

29d. Date signed (Month, Day, Year)

03-16-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Neil R Taylor Jr, Rising Sun, MD 21911

31. Date filed (Month, Day, Year)

MAR 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09331

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN PAUL KURILLA

2. Date of Death

MARCH 10, 1997

3. Time of Death

6:25 A.M.

4a. Facility Name (If not institution, give street and number)

GARRETT COUNTY MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

Funeral  
Director

5. Social Security Number

180-26-4101

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 21, 1936

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

417 SAM SNEAD CIRCLE

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MERCHANT

16b. Kind of Business/Industry

VARIETY STORE

17. Father's Name (First, Middle, Last)

PAUL

KURILLA

18. Mother's Name (First, Middle, Maiden Surname)

MARY

KURILA

19a. Informant's Name/Relationship (Type, Print)

BETTY KURILLA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

417 SAM SNEAD CIRCLE OAKLAND, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRETT MEMORIAL GARDENS

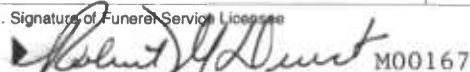
Date

3/13/97

20c. Location - City or Town, State

OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee

 MO0167

22. Name and Address of Facility

P.O. BOX 243

DURST FUNERAL HOME - OAKLAND, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial Infarction  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D23979

29d. Date signed (Month, Day, Year)

MARCH 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT A. GORALSKI, M.D.

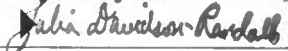
311 N. FOURTH ST. OAKLAND, MD 21550

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09332

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>James Howard Kidwell  |   |   | 2. Date of Death<br>Month Day Year<br>March 16, 1997   |  | 3. Time of Death<br>7:00 AM  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>12824 E. Shelby Lane  |   |   | 4b. City, Town, or Location of Death<br>Brandywine   |  | 4c. County of Death<br>Prince George's   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-26-4934  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>July 15, 1929   |  |
|   | Usual Residence of Decedent   |   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Prince George's  | 10c. City, Town or Location<br>Brandywine   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>12824 E. Shelby Lane  |   |   | 10f. Zip Code<br>20613   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: 1947-1951 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th<br>College (1-4 or 5+) N/A   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>State Highway Administration                   |  | 16b. Kind of Business/Industry<br>State Government   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Benjamin H. Kidwell  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth V. Boswell  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Christine E. Kidwell (Wife)   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12824 E. Shelby Lane Brandywine, MD 20613 |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland State Veterans Cem. 1997   |  | 20c. Location - City or Town, State<br>Cheltenham, Maryland  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   | 22. Name and Address of Facility<br>Lee Funeral Home, Inc.<br>6633 Old Alexandria Ferry Rd Clinton, Md 20735                               |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  | Approximate Interval Between Onset and Death |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Metastatic Carcinoma</u><br>Due to (or as a consequence of):<br>b. <u>CA Colon</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |   |   |  |  |  |  | 5 months<br>12 mo.                           |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |  |
|   |   | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>DD1923  |  | 29d. Date signed (Month, Day, Year)<br>March 17, 1997  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Thomas Fieldson M.D. Brandywine Waldorf Clinic Brandywine MD 20613-5907   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 18 1997  |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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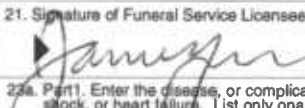

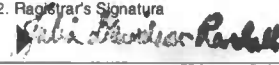


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09333

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Kovacs</b>                               |   |  |  | 2. Date of Death<br>Month <b>3</b> Day <b>8</b> Year <b>97</b> |  | 3. Time of Death<br><b>7:10p</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>        |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>111 16 3862</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 20, 1909</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Italy</b>   |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bowie</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>12423 Sussex Lane</b>  |   |   |  | 10f. Zip Code<br><b>20715</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> Collage (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Dominic Malardi</b>   |   |   |  | 16. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Unavailable</b>  |  |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Stephen Kovacs Husband</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12423 Sussex Lane Bowie Maryland 20715</b>   |  |  |  |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery March 12, 1997 Clinton Maryland</b>  |  | Data   |  | 20c. Location - City or Town, State  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Maryland 20715</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Diabetes</b><br>Due to (or as a consequence of):<br>c. <b>Ischemic heart disease</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 wk.</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>034400</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/10/97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrew Orbini 3251 Super Lane AG Bowie MD 20715</b>  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>   |   | 32. Registrar's Signature<br>  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09334  
Certificate of Death

Reg. No.

|  |  |   |                                  |  |   |   |   |  |
|--|--|---|----------------------------------|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EVELYN MAY LEWIS</b>                                |   |                                  |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> , Year <b>1997</b> |   | 3. Time of Death<br><b>9:45 A.M.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Nursing Home</b> |   |                                  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>                   |   | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-40-9159</b>  |   | 6. Sex<br><b>1</b> M <b>XX</b> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>July 29, 1910</b>                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |                                  |  |   |   |   |  |
| 10a. State<br><b>Delaware</b>  |  | 10b. County<br><b>New Castle</b>  |                                  | 10c. City, Town or Location<br><b>Wilmington</b>   |   |   | 10d. Inside City Limits<br><b>XX</b> Yes <b>2</b> No                                      |  |
| 10e. Street and Number<br><b>8 East Salisbury Drive</b>  |  |   |                                  | 10f. Zip Code<br><b>19809</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
| 11. Marital Status<br><b>XX</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>XX</b> No<br>If Yes, Give Year or Dates:   |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>XX</b> No Specify:         |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>College (1-4or 5+)</b><br><b>Two</b>  |  |   |                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Clerk</b>                            |   |   | 16b. Kind of Business/Industry<br><b>Braunsteins Dept. Store<br/>Wilmington, Delaware</b> |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Wesley Gilpin</b>   |  |   |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Iva May Campbell</b>   |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan E. Farren (Daughter)</b>  |  |   |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 East Salisbury Drive, Wilmington, Delaware 19809</b> |   |   |   |  |
| 20a. Method of Disposition<br><b>XX</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  |   |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>North East Methodist Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>North East, Maryland</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Thomas M. Patterson, Sr.</i>   |  |   |                                  | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home<br/>Perryville, Maryland 21903-0188</b>                                     |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. ALZHEIMER'S DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |                                  |  |   |   |   | Approximate Interval Between Onset and Death<br><b>YEARS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |  |
|  |  |   |                                  |  |   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |   |  |
|  |  |   |                                  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>Hospice</b> |                                  |  |   |   |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide<br><b>4</b> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |                                  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |   | 28d. Describe how injury occurred                            |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                  |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Davidson</i>   |  |   |                                  | 29c. License number<br><b>15504</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>3-14-97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. EDDIE NAKHODA 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>   |  |   |                                  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>  |  | 32. Registrar's Signature<br><i>Davidson</i>  |                                  |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09335

|  |   |   |   |   |   |  |  |  |
|--|---|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mary LOUISE Lane</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>March 17, 1997</b>   |  | 3. Time of Death<br><b>2:15 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Salisbury Center: Genesis Eldercare</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Salisbury, MD</b>  |  | 4c. County of Death<br><b>Wicomico</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-22-6881</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>05-08-1929</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Somerset</b>  |  | 10c. City, Town or Location<br><b>Crisfield</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>329 Cove ST</b>  |   | 10f. Zip Code<br><b>21817</b>   |  | 10g. Citizen of What Country?<br><b>U.S</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bishop</b>  |   | 16b. Kind of Business/Industry<br><b>Baptist Church Ministry</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Richard Lee</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mattie Bruington</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Stetson Lane Jr / Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 282 Crisfield, MD 21817</b> |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Family Cemetery</b>  |   | 20c. Date<br><b>3-22-97</b>   |  | 20d. Location - City or Town, State<br><b>Lawsonia, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Anthony E. Ward</b>   |   | 22. Name and Address of Facility<br><b>Anthony E. Ward Funeral Home<br/>314 Cove St. Crisfield, MD 21817</b>  |   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Aspiration pneumonia</b><br>Due to (or as a consequence of):<br><b>P66 Tube Feedings</b><br>Due to (or as a consequence of):<br><b>multiple strokes and dementia</b><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>&lt; 24°</b>  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospit: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  |
|  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how Injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D 39813</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/17/97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804</b> |   | 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b> |   | 32. Registrar's Signature<br><b>[Signature]</b> |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09336

## Certificate of Death

Reg. No.

|  |   |  |  |                                |  |
|--|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>JOHNNIE LOCKWOOD</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>8</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>2:39AM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |                                | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>245-44-4328</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>July 1, 1933</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |                                |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>  |                                | 10b. County<br><b>Prince George's</b>  |
|  | 10c. City, Town or Location<br><b>Hyattsville</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |
|  | 10e. Street and Number<br><b>5115 54th Avenue #2</b>  |  | 10f. Zip Code<br><b>20781</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd</b> College (1-4 or 5+) <b>Forklift Driver</b> |                                |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Private</b>   |  | 16b. Kind of Business/Industry   |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Roy Lockwood</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jeneva Davis</b>   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary V. Jackson</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5115 54th Avenue #2, Hyattsville, MD 20781</b>   |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National Cem.</b>  |                                | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Nancy A. Perentis</b>   |  | 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, MD 20785</b>                                      |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>acute myocardial infarction</b>   |  |  |                                | Approximate Interval Between Onset and Death<br><b>12 hrs.</b>   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |                                |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |                                |  |
|  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |                                |  |
|  | 29b. Signature and title of certifier<br><b>Lewis H. Dennis</b>   |  | 29c. License number<br><b>501499</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>MAR 8, 1997</b>  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Lewis H. Dennis, m.d. 6201 Greenbelt Road, College Park, Maryland</b>  |  |  |                                |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAR 14 1997</b>   |  | 32. Registrar's Signature<br><b>John A. Randall</b>  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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REPORT OF THE BOARD

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State of Maryland / Department of Health and Mental Hygiene

97 09337

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leila Gertrude Marra

2. Date of Death

March 6, 1997

3. Time of Death

10:23 PM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

215-34-4784

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar 25, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Garrett

10c. City, Town or Location

Accident

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

217 S. Main Street, P.O. Box 253

10f. Zip Code

21520

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Rodgers

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Kline

19a. Informant's Name/Relationship (Type, Print)

Beverly Kline/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Larch Lane, Middletown, MD 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bear Creek Church Cem, Mar 9, 1997

Date

20c. Location - City or Town, State

Accident, MD 21520

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A., P.O. Box 275,  
179 Miller Street, Grantsville, MD 2153623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. inanition

Due to (or as a consequence of):

1 month

b. dementia, senile onset

Due to (or as a consequence of):

30 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

29c. License number

D25759

29d. Date signed (Month, Day, Year)

March 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Walter K. Naumann, M.D., PO Box 247, Accident MD 21520

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



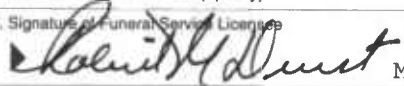
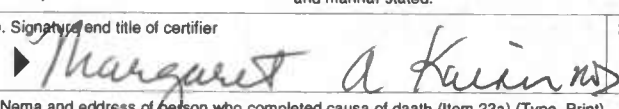
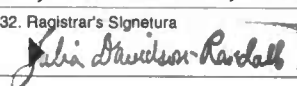


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09338

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |   |  |  |
|--|---|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PEARL (NMI) MARTIN</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 13, 1997</b>  |  | 3. Time of Death<br><b>3:50 PM</b>                                      |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>213 "E" STREET</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>MT. LAKE PARK</b>   |  | 4c. County of Death<br><b>GARRETT</b>                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>233-78-4605</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JAN 11, 1918</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>W. VA.</b>  |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>GARRETT</b>   | 10c. City, Town or Location<br><b>MT. LAKE PARK</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |
|  | 10a. Street and Number<br><b>213 "E" STREET</b>   |   |   | 10f. Zip Code<br><b>21550</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                     |  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>ORAS SNYDER</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GOLDIE OPAL WHITE</b>  |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LENORA REAMS - DAUGHTER</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>199 BRAY SCHOOL ROAD OAKLAND, MD 21550</b> |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. JOHN'S CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>3/16/97 RED HOUSE, MARYLAND</b>  |  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br> <b>MO0167</b>   |   |   | 22. Name and Address of Facility<br><b>P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550</b>   |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Complications of Fractured left hip</b><br>Due to (or as a consequence of):<br>b. <b>Weakness and weight loss</b><br>Due to (or as a consequence of):<br>c. <b>Presumed GI malignancy</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>6 weeks</b><br><b>6 months</b>  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>D26650</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/14/97</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Margaret A. Kaiser, MD, PO Box 486, Oakland, MD 21550</b>   |   |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 1997</b>  |   | 32. Registrar's Signature<br>  |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the report is a general  
description of the project and its objectives.  
2. The second part is a detailed description of the  
methodology used in the study.

3. The third part is a description of the results  
of the study, including the data collected and the  
analysis performed.

4. The fourth part is a discussion of the results  
and their implications, including a comparison with  
previous studies.

5. The fifth part is a conclusion and a summary  
of the findings of the study.

6. The sixth part is a list of references and a  
list of figures and tables.

7. The seventh part is a list of appendices and a  
list of abbreviations.

8. The eighth part is a list of acknowledgments and a  
list of contact information.

9. The ninth part is a list of footnotes and a list of  
endnotes.

10. The tenth part is a list of references and a list of  
figures and tables.

11. The eleventh part is a list of appendices and a  
list of abbreviations.

12. The twelfth part is a list of acknowledgments and a  
list of contact information.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09339

## Certificate of Death

Reg. No.

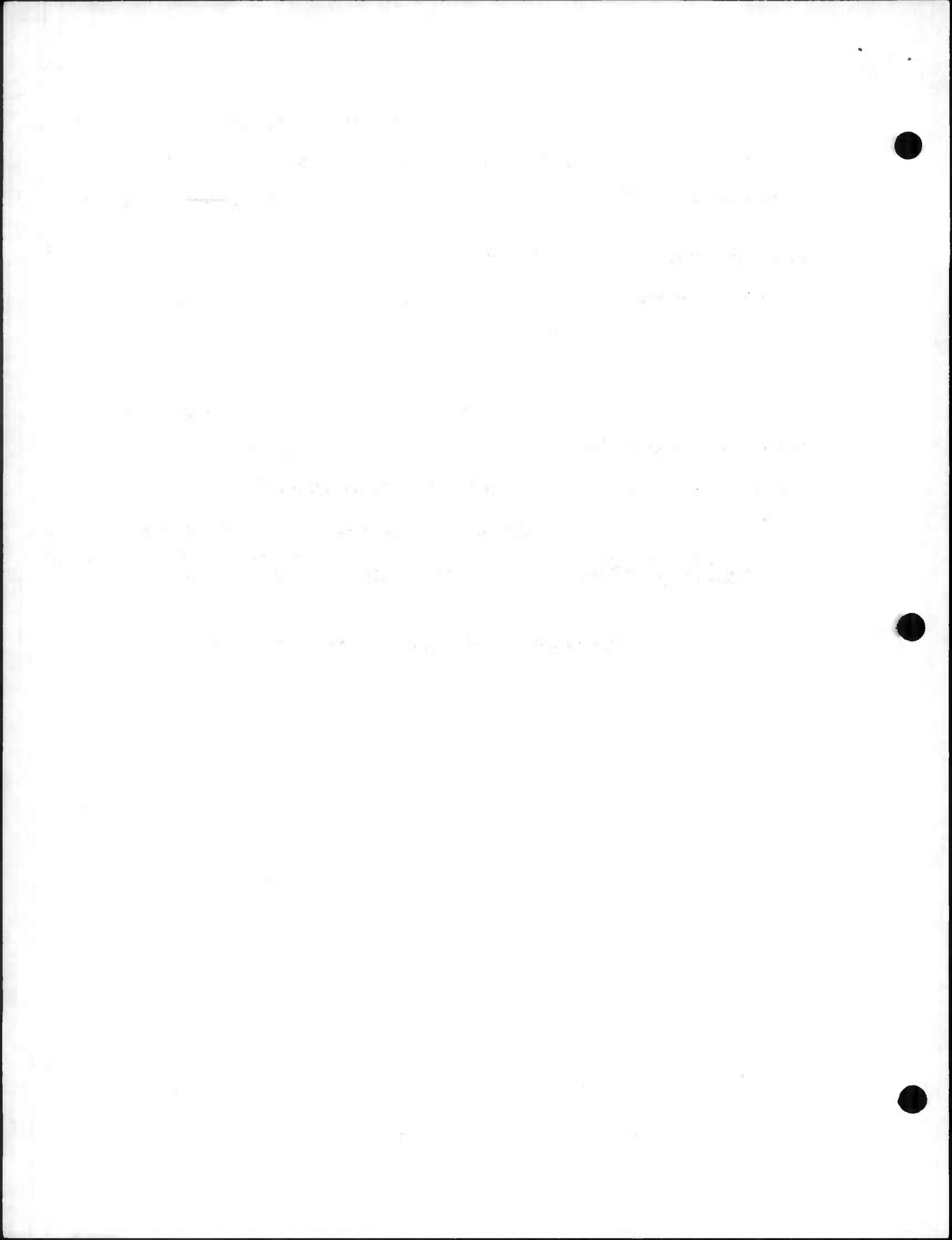
|   |  |                                       |   |   |   |   |   |  |
|---|--|---------------------------------------|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>John Francis Munson Sr.</u>   |                                       |   |   | 2. Date of Death<br>Month <u>March</u> Day <u>15</u> Year <u>1997</u>   |   | 3. Time of Death<br><u>6:05 P.M.</u>                                    |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><u>LA PLATA CENTER GENESIS ELDER CARE NETWORK</u>  |                                       |   |   | 4b. City, Town, or Location of Death<br><u>LA PLATA</u>   |   | 4c. County of Death<br><u>CHARLES</u>                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>216-14-5331</u>  |                                       | 6. Sex<br><u>1</u> M <u>2</u> F   |   | 7. Age (In yrs. last birthday)<br><u>76</u> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><u>JULY 11, 1920</u>             |  |
|   | 10a. State<br><u>MARYLAND</u>  |                                       | 10b. County<br><u>CHARLES</u>   |   | 10c. City, Town or Location<br><u>WALDORF</u>   |   | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No                     |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><u>#2825 MIDDLETOWN ROAD</u>   |                                       |   |   | 10f. Zip Code<br><u>20601</u>   |   | 10g. Citizen of What Country?<br><u>UNITED STATES</u>                   |  |
|   | 11. Marital Status<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>5TH GRADE</u> College (1-4or 5+)   |                                       |   |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>HEAVY EQUIPMENT OPERATOR</u>          |   | 16b. Kind of Business/Industry<br><u>GOVERNMENT</u>                     |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>JAMES H. MUNSON SR.</u>  |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>MARY BUTLER MUNSON</u>  |   |   |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><u>GALE MUNSON MOORE / DAUGHTER</u>  |                                       |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>16000 MEANDERING DRIVE, BRANDYWINE, MD. 20613</u> |   |   |  |
|   | 20e. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>ST. MARY'S CHURCH CEM.</u> |   | Data<br><u>3/20/97</u>  |   | 20c. Location - City or Town, State<br><u>CLINTON, MARYLAND</u>         |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Thorton Johnson</u><br>ADIA C. THORNTON JOHNSON M00583   |                                       |   |   | 22. Name and Address of Facility<br><u>THORNTON FUNERAL HOME, P.A.</u><br><u>3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640</u>                         |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p><u>Chronic Obstructive Pulmonary Disease</u><br/>Due to (or as a consequence of):<br/><u>Recently Acquired Pneumonia</u><br/>Due to (or as a consequence of):<br/><u>Demerol</u><br/>Due to (or as a consequence of):</p> |                                       |   |   |   |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                       |   |   |   |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown  |                                       |   |   |   |   |   |  |
| 24e. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No  |  |                                       |   |   |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No   |  |                                       |   |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No  |  |                                       |   |   |   |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)  |  |                                       |   |   |   |   |   |  |
| 27. Manner of Death<br><u>1</u> Natural <u>2</u> Accident <u>3</u> Suicide <u>4</u> Homicide  |  | 28e. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br><u>M</u>                     |   | 28c. Injury at Work?<br><u>1</u> Yes <u>2</u> No      |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred     |   |   |   |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28e. Date of Injury (Month, Day Year) |   |   |   |   |   |  |
| 29a. Certifier (Check only one)<br><u>1</u> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                       |   |   |   |   |   |  |
| 29b. Signature and title of certifier<br><u>John A. Johnson</u>   |  |                                       |   | 29c. License number<br><u>20629</u>                 |   | 29d. Date signed (Month, Day, Year)<br><u>3/16/97</u> |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>George W. Waldorf</u><br><u>WALDORF 20603</u>  |  |                                       |   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>MAR 18 1997</u>   |  |                                       |   | 32. Registrar's Signature<br><u>John A. Johnson</u> |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



DHHM 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

97 09341

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Agnes Estelle Meyer

2. Date of Death

Month Day Year  
March 8, 1997

3. Time of Death

2:20 pm

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

220-50-9054

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 18, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7704 Powhatan Street

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Mitchell Higgs

18. Mother's Name (First, Middle, Maiden Surname)

Julia Mae Busch

19a. Informant's Name/Relationship (Type, Print)

George I. Meyer - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7704 Powhatan Street, New Carrollton, MD 20784

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

03/12/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

2 Weeks

b. Atrial Fibrillation

Due to (or as a consequence of):

Years

c. Cardio Vascular Disease

Due to (or as a consequence of):

Years

d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33508

29d. Date signed (Month, Day, Year)

3/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Weisher, M.D. 7525 Greenway Center Drive T-8, Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09342

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET

MARSHALL

2. Date of Death

March

Day

Year

3. Time of Death

11:00 pm

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-74-1332

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

07-11-50

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Prince George's

Mt. Rainier

1 ☒ Yes 2 ☐ No

10e. Street and Number

4617 22nd Avenue

10f. Zip Code

20712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married  
 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 1 ☐ Yes 2 ☒ No  
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Care Giver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Charles Henry Marshall Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Catherine D. Contee

19a. Informant's Name/Relationship (Type, Print)

Charles Marshall Jr./ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5318 85th Ave. #T1 New Carrollton, MD 20784

20a. Method of Disposition

 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

3/10/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Pneumocystis Pneumonia

Due to (or as a consequence of):

c. AIDS

Due to (or as a consequence of):

d. Intravenous Drug Abuse

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

CIRRHOSIS OF LIVER

HEPATITIS C infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

 1 ☒ Natural 5 ☐ Pending investigation  
 2 ☐ Accident 6 ☐ Could not be determined  
 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

J. Bedeau, MD

29c. License number

D 30666

29d. Date signed (Month, Day, Year)

3-06-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN W. BEDEAU, MD 12164 Central Ave, MITCHELLVILLE, MD 20721

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John A. Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

100315

100315

MAR 13 1965

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09343

## Certificate of Death

Reg. No.

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>STEVEN MARSHALL</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>6</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>10:55 PM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |   | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-48-8688</b>   | 6. Sex<br><b>152 M 20 F</b>  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>June 22, 1939</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>  |
|  | 10c. City, Town or Location<br><b>Capital Heights</b>   |  | 10d. Inside City Limits<br><b>1X Yes 20 No</b>   |   |  |
|  | 10e. Street and Number<br><b>1200 Boones Hill Road, #2</b>  |  | 10f. Zip Code<br><b>20743</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><b>10 Never Married 2X Married</b><br><b>30 Widowed 40 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1X Yes 20 No</b><br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>10 Yes 2X No Specify:</b> |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                       |   | 16b. Kind of Business/Industry<br><b>Government Sanitation Dept.</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Steven Henry Jones Marshall, Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susie Mae Redfern</b>  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gladys I. Coates Marshall - Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1200 Boones Hill Road, #2, Capital Heights, MD</b> |   |  |
|  | 20a. Method of Disposition<br><b>1X Burial 20 Cremation 30 Removal from State</b><br><b>40 Donation 50 Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>   |   | 20c. Location - City or Town, State<br><b>3/14/97 Landover, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>   |  | 22. Name and Address of Facility<br><b>STEWART FUNERAL HOME, Inc.</b><br><b>4001 Benning Road, N.E., Washington, D.C.</b>                              |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Esophageal variceal bleeding</b><br>Due to (or as a consequence of):<br><b>b. Cirrhosis</b><br>Due to (or as a consequence of):<br><b>c. metastatic cancer</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Seizures</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>10 Yes 2X No 30 Probably 40 Unknown</b>   |  |   |  |
| 24a. Was an autopsy performed?<br><b>10 Yes 2X No</b>  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>10 Yes 2X No</b>   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>10 Yes 2X No</b>  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1X Inpatient 20 ER/Outpatient 30 DOA</b> Other: <b>40 Nursing Home 50 Residence 60 Other (Specify)</b> |  |   |  |
| 27. Manner of Death<br><b>1X Natural 50 Pending investigation</b><br><b>20 Accident 60 Could not be determined</b><br><b>30 Suicide 40 Homicide</b>  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>                       |  |
| 28c. Injury at Work?<br><b>10 Yes 20 No</b>  |   | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><b>1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>L. Bahaduri, M.D.</b>  |   | 29c. License number<br><b>D47928</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/10/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>L. Bahaduri PGHC Cheverly, MD</b>   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>  |   | 32. Registrar's Signature<br><b>John T. Stewart III</b>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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97 09344

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>David Lee Nordberg   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 12, 1997   |  | 3. TIME OF DEATH<br>9:30 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-24-4928   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>68 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>September 7, 1928  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>25630 Garey Road   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Denton  |  |
| 9c. COUNTY OF DEATH<br>Caroline  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Caroline  |  |
| 10c. CITY, TOWN OR LOCATION<br>Denton  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>25630 Garey Road   |  |
| 10f. ZIP CODE<br>21629   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Caucasian  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>11 HS Grad.   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Poultry Inspector   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Department of Agriculture   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles August Nordberg   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Grace Skipper  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Rena W. Nordberg Wife  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>25630 Garey Road, Denton, Maryland 21629  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Denton Cemetery   |  | 20c. LOCATION — City or Town, State<br>3/15 Denton, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Handwritten Signature</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Moore Funeral Home, P.A.<br>12 South Second St., Denton, MD 21629  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic lung carcinoma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Approximate Interval Between Onset and Death<br>1 year |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>chronic obstructive pulmonary disease</i><br><i>coronary artery disease</i>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Handwritten Signature</i>  |  |  |  | 29c. LICENSE NUMBER<br>035749  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/13/97   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>503 Dutchen Lane Easton MD 21601 (Gregg David Oliver, M.D.)   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 14 97   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Handwritten Signature</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09345

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Alton L. Nathaniel</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>4</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>11:00 A.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ADVANTAGE ELDERLY CARE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>   |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>457-20-3408</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 1, 1920</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Crockett, Tex.</b>                           |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>District of Columbia</b>   | 10b. County<br><b>Washington</b>   | 10c. City, Town or Location<br><b>Washington</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>3544 Texas Avenue, S. E.</b>   |  |   | 10f. Zip Code<br><b>20020</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>African American</b>       |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired Procurement Supervisor</b>  |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Eugene Nathaniel</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hester (Unknown)</b>   |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Zelma E. Nathaniel - Wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3544 Texas Avenue, S. E., Washington, D.C. 20020</b> |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  | 20c. Date<br><b>3/10/97</b>  |  | 20d. Location - City or Town, State<br><b>Landover, MD</b>                                  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>   |  | 22. Name and Address of Facility<br><b>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N. E., Washington, D.C.</b>  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Myocardial infarction</b><br>Due to (or as a consequence of):<br><b>Coronary artery disease</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Alzheimer's disease</b><br><b>Cerebrovascular disease</b> |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br><b>Dr. Ronald Wheeler</b>  |  | 29c. License number<br><b>D37529</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-5-97</b>   |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>8300 Corporate Drive Landover MD 20785</b>   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 12 1997</b>  |   | 32. Registrar's Signature<br><b>John [Signature]</b>                       |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09346

## Certificate of Death

Reg. No.

|  |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|--|--|------------------------------------|---|---|--|--|--|--|---|------------------------------------|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|---|---------------------------------|--|--|--|--|--|--------------|----------------------------------|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|---------------|----------------------------------|--|--|--|--|--|--|------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Julia R. Le Pera</i>  |                                    |   |   | 2. Date of Death<br>Month <i>03</i> Day <i>16</i> Year <i>96</i>   |  | 3. Time of Death<br><i>5:45PM</i>  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Rockville Nursing Home</i>  |                                    |   |   | 4b. City, Town, or Location of Death<br><i>Rockville</i>   |  | 4c. County of Death<br><i>Montgomery</i>   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>221-18-4199</i>  |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>87</i> Yrs.  | If Under 1 Year<br>Months Days   | 8. Date of Birth (Month, Day, Year)<br><i>April 24, 1909</i>                 | 9. Birthplace (State or Foreign Country)<br><i>Leetonia, Ohio</i>                              |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 10e. State<br><i>Maryland</i>  |                                    | 10b. County<br><i>Montgomery</i>  |   | 10c. City, Town or Location<br><i>Rockville</i>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><i>303 Adclare Rd.</i>   |                                    |   |   | 10f. Zip Code<br><i>20850</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+) <i></i>  |                                    |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Seamstress</i>   |  | 16b. Kind of Business/Industry<br><i>Clothing Industry</i>                                     |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Vincenzo Rizzo</i>   |                                    |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Angeline Venneri</i>   |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><i>Mario E. LePere</i>   |                                    |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4746 Occoquan Club Dr., Woodbridge, VA 22192</i>   |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>St. John's Cemetery</i>  |   | Date<br><i>Mar. 18, 1997</i>   |  | 20c. Location - City or Town, State<br><i>Newark, Delaware</i>                                 |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |                                    |   |   | 22. Name and Address of Facility<br><i>Robert T. Jones &amp; Foard, Inc. 19711<br/>122 West Main Street Newark, Delaware</i>   |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">e. <i>Congestive Heart Failure</i></td> <td>Approximate Interval Between Onset and Death<br/><i>2 yrs</i></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">{</td> <td colspan="6">b. <i>Chronic Renal Failure</i></td> <td><i>3 yrs</i></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list condition(s), if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="6">c. <i>Atherosclerosis</i></td> <td><i>15 yrs</i></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">d. <i></i></td> <td></td> </tr> </table> |                                    |   |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | e. <i>Congestive Heart Failure</i> |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>2 yrs</i> | Due to (or as a consequence of): |  |  |  |  |  |  | { | b. <i>Chronic Renal Failure</i> |  |  |  |  |  | <i>3 yrs</i> | Due to (or as a consequence of): |  |  |  |  |  |  | Sequentially list condition(s), if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. <i>Atherosclerosis</i> |  |  |  |  |  | <i>15 yrs</i> | Due to (or as a consequence of): |  |  |  |  |  |  | d. <i></i> |  |  |  |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)  | e. <i>Congestive Heart Failure</i> |   |   |  |  |  | Approximate Interval Between Onset and Death<br><i>2 yrs</i> |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| Due to (or as a consequence of):   |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| {  |  | b. <i>Chronic Renal Failure</i>    |   |   |  |  |  | <i>3 yrs</i>   |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  |  | Due to (or as a consequence of):   |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| Sequentially list condition(s), if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | c. <i>Atherosclerosis</i>  |                                    |   |   |  |  | <i>15 yrs</i>  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
|  | Due to (or as a consequence of):   |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| d. <i></i>   |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic obstructive pulmonary disease</i>   |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 28e. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M           |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                    |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |                                    |   | 29c. License number<br><i>D33443</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>March 13, 1997</i>                 |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Alan R Pollack, M.D. 809 Viers Mill Rd Rockville, Md 20851</i>  |  |                                    |   |   |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 17 1997</i>  |  |                                    |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>                                  |  |  |  |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |   |                                 |  |  |  |  |  |              |                                  |  |  |  |  |  |  |  |                           |  |  |  |  |  |               |                                  |  |  |  |  |  |  |            |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09347

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |  |  |  |
|---|---|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Roy</b>  |  |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>11</b> Year <b>1997</b> |  |  | 3. Time of Death<br><b>2:30 P.M.</b>   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Medical Center</b> |  |   | 4b. City, Town, or Location of Death<br><b>Cheverly</b>               |  |  | 4c. County of Death<br><b>Prince George's</b>                                    |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>235-09-6875</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>May 24, 1915</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   |  | 10b. County<br><b>Prince George's</b>   |   |  | 10c. City, Town or Location<br><b>Capitol Heights</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>6701 Dry Log Street</b>  |   |  | 10f. Zip Code<br><b>20743</b>   |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1941-</b><br>If Yes, Give Year or Dates: <b>1945</b>  |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b>   |   |  | College (1-4 or 5+) <b>N/A</b>  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>  |  |  | 16b. Kind of Business/Industry<br><b>Local Union 132</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Patterson Pennell</b>   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Mink</b>   |   |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Panzy E. Pennell (Wife)</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6701 Dry Log Street Capitol Heights, MD 20743</b>   |   |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee Crematory</b>  |   |  | Date<br><b>March 12, 1997</b>  |  |  | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc.<br/>6633 Old Alexandria Ferry Rd Clinton, Md 20735</b>  |   |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebral hemorrhage</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |  | Approximate Interval Between Onset and Death<br><b>3 days</b>  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  | 29b. Signature and title of certifier<br><b>H. Thomas Foley, M.D.</b>   |   |  | 29c. License number<br><b>DO5698</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>3-12-97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. Thomas Foley, M.D., Prince George's Hosp. Cen., Cheverly, MD 20743</b>  |   |  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>   |   |  | 32. Registrar's Signature<br><b>Julia Davidson Randall</b>  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Page 10 of 10

...

...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09348

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Theresa Purdy

2. Date of Death

Month Day Year  
March 15, 19973. Time of Death  
8:30PM

4e. Facility Name (If not institution, give street and number)

404 Saddle Ridge Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director5. Social Security Number  
577-01-63036. Sex  
1 ☐ M ☒ F7. Age (In yrs. last birthday)  
82 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
June 5, 19149. Birthplace (State or Foreign  
Country)  
Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

404 Saddle Ridge Road

10f. Zip Code

21403

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10thCollege (1-4 or 5+)  
N/A16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John Milton

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Mahorney

19a. Informant's Name/Relationship (Type, Print)

Patricia Boteler (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

404 Saddle Ridge Road Annapolis MD 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date  
March 18,

1997

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry RD Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or head failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. Coronary artery disease  
Due to (or as a consequence of):b. IHD  
Due to (or as a consequence of):c. Diabetes  
Due to (or as a consequence of):

d. Peripheral vascular disease

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

02P686

29d. Date signed (Month, Day, Year)

3/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Victor Plavner M.D. 1509 Ritchie Highway Arnold Md 21012

31. Date filed (Month, Day, Year)

MAR 18 1997

32. Registrar's Signature

John Duckworth Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
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once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner



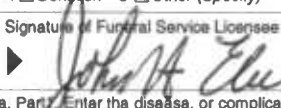
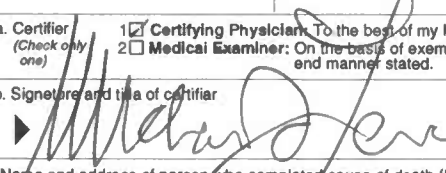
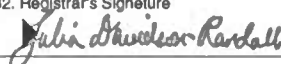
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09349

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |  |   |
|---|---|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Nolan M. Presnell Sr</b>   |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>16</b> Year <b>1997</b>                          |  | 3. Time of Death<br><b>2:00p.m.</b>                        |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Fort Washington Hospital</b>   |   |  |   | 4b. City, Town, or Location of Death<br><b>Fort Washington</b>                                 |  | 4c. County of Death<br><b>Prince's George</b>              |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>239-36-2231</b>   |   | 6. Sex<br><b>XX</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month, Day, Year<br><b>JAN 21 1928</b> | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b> |
|   | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Prince George's</b> 10c. City, Town or Location <b>Fort Washington</b> |   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |
| 10e. Street and Number<br><b>11201 Livingston Road</b>  |   | 10f. Zip Code<br><b>20744</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW 11</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Brick Mason</b>   |  | 16b. Kind of Business/Industry<br><b>Construction</b>   |  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Benjamin H. Presnell</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Treva Hayes Presnell</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Cecelia E. Presnell (Wife)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11201 Livingston Rd Fort Washington, MD 20744</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>3-18-97 Alexandria, VA</b>  |  |  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>J.H. Eberwein Mortuary</b><br><b>4433 White Pls La White Pls, MD 20695</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Probable Acute MI</b> |  | Approximate Interval Between Onset and Death<br><b>1HR</b>   |  |   |
| 23a. Immediate Cause (Final disease or condition resulting in death)<br><b>ASHD</b>   |   | Due to (or as a consequence of):<br><b>ASHD</b>   |  | Due to (or as a consequence of):  |  | Due to (or as a consequence of):   |  |   |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   | Due to (or as a consequence of):  |  | Due to (or as a consequence of):  |  | Due to (or as a consequence of):   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes, Hypercholesterolemia</b>   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |  |  |   |
|   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   | 28d. Describe how injury occurred   |  | 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D24945</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 17, 1997</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Michael Levene MD 7801 Old Branch Av #409 Clinton, MD 20735</b>  |   |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>   |   | 32. Registrar's Signature<br>  |  |   |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09350

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AGNES

M.

PROPST

2. Date of Death

Month

Day

Year

MARCH 14 1997

3. Time of Death

2055

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

214-30-7650

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

11/20/1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

SOMERSET

10c. City, Town or Location

PRINCESS ANNE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9951 ARDEN STATION ROAD

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LUTHER SHANLEY DOUGHERTY

18. Mother's Name (First, Middle, Maiden Surname)

ANNA SEIGFRIED

19a. Informant's Name/Relationship (Type, Print)

ERNEST PROPST/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9951 ARDEN STATION ROAD, PRINCESS ANNE, MD. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BEECHWOOD CEMETERY

Date

03/17/97

20c. Location - City or Town, State

PRINCESS ANNE, MD.

21. Signature of Funeral Service Licensee

M00295

22. Name and Address of Facility

HINMAN FUNERAL HOME

11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *metastatic cancer*  
Due to (or as a consequence of):

Approximate interval Between Onset and Death

6 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diabetes**Hypertension**meningoma*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25219

29d. Date signed (Month, Day, Year)

3-14-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES STEGMAN MD 30434 MT. VERNON RD. PRINCESS ANNE MD. 21853

31. Date filed (Month, Day, Year)

MAR 17 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09351

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Maisie M. Pickett

2. Date of Death

Month  
MarchDay  
14Year  
1997

3. Time of Death

6:30 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Golden Age Guest Home

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

217-28-6167

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 13, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1442 Buckhorn Road

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Haugh

18. Mother's Name (First, Middle, Maiden Surname)

Susie Lewis

19a. Informant's Name/Relationship (Type, Print)  
Mrs. Marjorie F. Pickett in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1929 Gillis Falls Road Woodbine, MD 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Taylorsville Ch. Cemetery 3/17

Date

20c. Location - City or Town, State

Taylorsville, Maryland

21. Signature of Funeral Service Licensee

James B. Covey

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.

1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. DEMENTIA, PRIMARY

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

71 YR

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. HEMOLYTIC ANEMIA

Due to (or as a consequence of):

73 YRS.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patrick Turney

29c. License number

D20806

29d. Date signed (Month, Day, Year)

3/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK TURNEY, MD 1425 Liberty Rd Eldersburg, MD 21784

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09352

## Certificate of Death

Reg. No.

|   |  |  |   |   |   |   |  |   |  |
|---|--|--|---|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Warren John Parks  |  |   |   | 2. Date of Death<br>Month Day Year<br>March 6, 1997   |   | 3. Time of Death<br>5:30 PM  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Charlotte Hall Veteran's Home  |  |   |   | 4b. City, Town, or Location of Death<br>Charlotte Hall  |   | 4c. County of Death<br>St. Mary's  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>075-07-7462   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>76 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Jan. 17, 1921  |  | 9. Birthplace (State or Foreign Country)<br>Watertown, N.Y.   |  |
|   | Usual Residence of Decedent  |  |   |   |   |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Prince George's   | 10c. City, Town or Location<br>Camp Springs   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |  |   |  |
|   | 10e. Street and Number<br>4722 Henderson Rd.   |  |   | 10f. Zip Code<br>20748  |   | 10g. Citizen of What Country?<br>USA  |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: ret. 1973 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Retired U.S.M.C.   |   | 16b. Kind of Business/Industry<br>Military  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Alfred Parks  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gertrude LaForty   |   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary A. Parks/Wife   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as item 10  |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cem.   |   | Date<br>3/13/97   |   | 20c. Location - City or Town, State<br>Arlington, Va.  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745   |   |  |   |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>chronic arteriosclerotic</i><br>Due to (or as a consequence of):<br>b. <i>cardiomyopathy</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |   |  |   | Approximate Interval Between Onset and Death |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|   |  |  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)                                      |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |   |   |  |   |  |
| 29b. Signature and title of certifier<br>   |  |  |   | 29c. License number<br>D12705   |   | 29d. Date signed (Month, Day, Year)<br>3/8/97   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Emad Al-Banna, M.D. 1050 Solomon Island Rd. Prince Frederick, Md.   |  |  |   |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 10 1997  |  |  |   | 32. Registrar's Signature<br>   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09353

Reg. No.

|   |   |   |  |   |   |  |                                   |  |
|---|---|---|--|---|---|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARY L. PAYNE                             |   |  |   | 2. Date of Death<br>Month Day Year<br>MAR 9 1997      |  | 3. Time of Death<br>8:50 AM       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital |   |  |   | 4b. City, Town, or Location of Death<br>Silver Spring |  | 4c. County of Death<br>Montgomery |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-68-5909  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>98 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>April 1, 1898  | 9. Birthplace (State or Foreign Country)<br>Virginia   |                                   |  |
|   | Usual Residence of Decedent   |   |  |   |   |  |                                   |  |
| 10a. State<br>MD  |   | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Silver Spring  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                   |  |
| 10e. Street and Number<br>2412 Harmon Rd  |   | 10f. Zip Code<br>20902  |  | 10g. Citizen of What Country?<br>U.S.A.   |   |  |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify Black                                  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4th College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Domestic   |   | 16b. Kind of Business/Industry<br>Self-Employed  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Maylor Levinberry  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Blanche Page   |   |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>George E. Levinberry-Brother  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>230 Rhode Island Ave. NE, #501 Wash, DC 20002  |   |  |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |  | 20c. Location - City or Town, State<br>3-12-97 Silver Spring, MD  |   |  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>J. P. Marshall   |   |   |  | 22. Name and Address of Facility<br>Marshall's Funeral Home, Inc.<br>4217 9th Street N.W. Washington, DC 20011  |   |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. RESPIRATORY FAILURE<br>Due to (or as a consequence of):<br>b. HYPOXEMIA<br>Due to (or as a consequence of):<br>c. RENAL FAILURE<br>Due to (or as a consequence of):<br>d. CONGESTIVE HEART FAILURE<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |   |  |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |   |   |  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |   |   |  |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |   |   |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  | 26. Piece of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |                                   |  |
| 28d. Describe how Injury occurred   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |                                   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |   |  |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |   |   |  |                                   |  |
| 29b. Signature and title of certifier<br>D. Vikramaditya Reddy  |   |   |  | 29c. License number<br>D43464   |   | 29d. Date signed (Month, Day, Year)<br>MAR - 10 - 1997   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>VIKRAMADITYA D. REDDY, 11125 ROCKVILLE PIKE, SUITE #303, ROCKVILLE, MD - 20852  |   |   |  |   |   |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 11 1997  |   |   |  | 32. Registrar's Signature<br>[Signature]  |   |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DREW MATTHEW PEARSON</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 26, 1997</b>   |  | 3. Time of Death<br><b>1:20PM</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LAUREL REGIONAL HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>LAUREL</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                            |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-76-7967</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 10, 1956</b>            |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Dist. Of Colum.</b>   |  | 10a. State<br><b>D. C.</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Washington</b>                        |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1529 Twenty-fifth Street, Northeast</b>  |  | 10f. Zip Code<br><b>20020</b>  |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>                        |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                     |  | 16b. Kind of Business/Industry<br><b>Private</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Curtis Pearson</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Webb</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bettie McDonald (Sister)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5005 Hunt Street, NE., Washington, D. C. 20019</b>                                       |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Natl Cemetery</b>   |  | 20c. Date<br><b>03/05/97</b>   |  | 20d. Location - City or Town, State<br><b>Laurel, Maryland</b>          |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>L. W. Plunkett, Inc. Fmr Home</b>  |  | 22. Name and Address of Facility<br><b>2504 - 28th St., NE., Washington, D.C. 20018-1413</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Acute Coronary Thrombosis</i><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined               |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                      |  |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Theodore M. King</i>   |  |  |   |  |  |  |   |  |
| 29c. License number<br><b>O.C.M.E.</b>   |  |  |   |  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 27, 1997</b>  |  |  |   |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 12 1997</b>  |  |  |   |  |  |  |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09355

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA DIANE PIPER

2. Date of Death

MARCH 8, 1997

3. Time of Death

1:20 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-74-6640

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

FEB. 9, 1956

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2820 PIN OAK LANE

10f. Zip Code

20785-2764

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

GEORGE ATKINS

18. Mother's Name (First, Middle, Maiden Surname)

LUCY GARDNER

19a. Informant's Name/Relationship (Type, Print)

TARA Y. BARNER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2820 PIN OAK LN, LANDOVER, MARYLAND 20785-2764

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

3/15/97 LANDOVER, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility L. W. PLUNKETT, INC. FNRL HOME

2504 - 28th St., NE., Wash., D.C. 20018-1413

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acquired immune deficiency syndrome 10 yrs  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

refractory metabolic acidosis,  
multiple electrolyte abnormalities

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8630 Fenton St #230, Silver Spring MD 20910

Lynette H. Posorske, M.D.

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

Julia Stueper Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 09356

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Magdalene Proctor</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 06 1997</b>  |  | 3. TIME OF DEATH<br><b>2:50 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>228-26-9140</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 7, 1915</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Villa Rosa Nursing Home</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Mitchellville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince George's</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Capitol Heights</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>511 Cedarleaf Avenue</b>  |  |
| 10f. ZIP CODE<br><b>20743</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housekeeper</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Contee</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Jackson</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Escaline Proctor/Daughter</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>511 Cedarleaf Avenue, Capitol Hgts, MD 20743</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park 3/11/97</b>  |  | 20c. LOCATION — City or Town, State<br><b>Landover, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, MD 20785</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End Stage Renal Disease</b> months<br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Hypertensive Cardiovascular Disease</b> months<br>b. <b>Diabetic Nephropathy</b> yrs.<br>c. <b></b><br>d. <b></b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Carcinoma of Breast</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Rakesh Arora, MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D20108</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/6/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Rakesh Arora, M.D., 14300 Gallant Fox Lane, Suite 222, Bowie, Maryland 20715</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 13 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09357

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>STEPHEN POPE</b>  |   |  |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>8</b> Year <b>1997</b> |  | 3. Time of Death<br><b>3:12 AM</b>                            |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Livingston Health Care Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Ft. Washington</b>        |  | 4c. County of Death<br><b>Prince George</b>                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-10-6343</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>August 27, 1900</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b>                                      |   | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>PRINCE GEORGES</b>                                 |  | 10c. City, Town or Location<br><b>CLINTON</b>                 |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>7712 MIKE SHAPIRO DRIVE</b>  |  | 10f. Zip Code<br><b>20735</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>  |  | 16b. Kind of Business/Industry<br><b>PRIVATE INDUSTRY</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>LOUIS POPE</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FANNIE (UNKNOWN)</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY POPE/ WIFE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7712 MIKE SHAPIRO DRIVE CLINTON, MARYLAND 20735</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>3-14-97 LANDOVER, MARYLAND</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Kimberly C. Busca-Tonic</b>  |  | 22. Name and Address of Facility<br><b>MARSHALL'S FUNERAL HOME</b><br><b>4308 SUITLAND ROAD SUITLAND, MD 20746</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>PLEURAL EFFUSION</b><br>Due to (or as a consequence of):<br><b>RENAL FAILURE</b><br><br>b. <b>METASTATIC PROSTATE CANCER</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate interval Between Onset and Death<br><br>2 weeks<br><br>8 weeks<br><br>1 year   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D32800</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 8, 1997</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hilary H. Washington, MD 11701 Livingston Rd #205 Ft. Washington, MD 20744</b>  |  |   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





97 09358

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Ola Abel Payne</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 9, 1997   |  | 3. TIME OF DEATH<br>10:45 pm M  |  |
| 4. SOCIAL SECURITY NUMBER<br>577-22-2594   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>91 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan. 29, 1906   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br>Greenbelt  |  | 9b. COUNTY OF DEATH<br>Prince George's  |  |
| 9c. FACILITY NAME (If not institution, give street and number)<br>Greenbelt Nursing Home   |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Prince George's   |  | 10c. CITY, TOWN OR LOCATION<br>College Park   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>8700 50th Place  |  |  |  | 10f. ZIP CODE<br>20740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Seamstress  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Private Industry  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Miles Abel  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna (last name unknown)   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Henry E. Armstrong -- Nephew   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8700 50th Place, College Park, Maryland 20740  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>National Memorial Park 03/13/97   |  | 20c. LOCATION — City or Town, State<br>Falls Church, Virginia   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Francis Gasch</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Diffuse Vascular Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pulmonary Embolus July 1996, Old Stroke, Right Hemiparesis, Impaired Swallowing, Dementia.</i>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TYPE OF CERTIFIER<br><i>Stuart Turkowitz M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br>D31001   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/10/97  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Stuart Turkowitz, M.D. 7500 Greenway Ctr. Dr. #430 Greenbelt, Md. 20770.</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 13 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09359

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Louise E. Ryan</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>4:05 PM</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Bayside Center 21412 Great Mills Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Lexington Park</b>  |  | 4c. County of Death<br><b>St. Mary's</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578 46 4444</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1909 Virginia</b>  |  |
|   | 10a. State<br><b>Maryland</b>   |  |   |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>Forestville</b>  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>6202 Elmhurst Street</b>   |  |   |  | 10f. Zip Code<br><b>20747</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>File Clerk</b>  |  | 16b. Kind of Business/Industry<br><b>Association of U.S. Army</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Luther Carroll Embrey</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Naomi Jones</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eunice R. Woods</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6202 Elmhurst Street, Forestville, Md 20747</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Holly Baptist Church Cem. Remington, Virginia</b>  |  | 20c. Location - City or Town, State  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Charles L. Belanger</b>   |  |   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. BILATERAL PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 WKS</b> |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br><b>Richard Kelly M.D.</b>  |  |   |  | 29c. License number<br><b>D 06018</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH, 12, 1997</b>  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RICHARD KELLY M.D. 5021 SEMINARY RD, ALEX, VA, 22311</b>   |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>John Davidson Randall</b>  |  |  |  |

Baltimore, Maryland 21215-0020

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97 09360

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>John LAWRENCE Reifsnider</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>3</i> - DAY <i>12</i> - YEAR <i>97</i>  |  | 3. TIME OF DEATH<br><i>10:30 P.M.</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-12-7583</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>82</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>March 29, 1914</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>COLLEGE VIEW NURSING CENTER</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>FREDERICK</i>  |  |
| 9c. COUNTY OF DEATH<br><i>FREDERICK</i>   |  |  |  | 10a. STATE<br><i>MARYLAND</i>  |  | 10b. COUNTY<br><i>CARROLL</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>UNION BRIDGE</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>11928 GREEN VALLEY ROAD</i>   |  |
| 10f. ZIP CODE<br><i>21791</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>UNITED STATES</i>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>W.W.II</i>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>3</i> College (1-4 or 5+) <i>3</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>DIRECTOR</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>LUMBER/HARDWARE</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>JOHN LAWRENCE REIFSNIDER, JR.</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>LETHE LISLE</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MARGARET C. REIFSNIDER</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>11928 GREEN VALLEY RD, UNION BRIDGE, MD 21791</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>CARROLL CREMATION</i>  |  | 20c. LOCATION — City or Town, State<br><i>HAMPSTEAD, MARYLAND</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert A. Myers</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>MYERS FUNERAL HOME<br/>91 WILLIS STREET, WESTMINSTER, MD 21157</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></i>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert A. Myers, MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D13971</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3/12/97</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>MAR 13 1997</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09361

## Certificate of Death

Reg. No.

|  |  |   |   |  |   |  |  |   |  |
|--|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Howard Pearson Reynolds  |   |   |  | 2. Date of Death<br>Month Day Year<br>March 10, 1997  |  | 3. Time of Death<br>11:05pm                                      |   |  |
|  | 4e. Facility Name (If not Institution, give street and number)<br>Scotties Home Care 9603 Beechwood Avenue   |   |   |  | 4b. City, Town, or Location of Death<br>Seabrook MD   |  | 4c. County of Death<br>P.G.                                      |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>579-20-0219   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>88 Yrs.   | If Under 1 Year<br>Months Days               | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>April 27, 1908  |  | 9. Birthplace (State or Foreign Country)<br>Pittsburg PA  |  |
|  | Usual Residence of Decedent  |   |   |  |   |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>DC   | 10b. County   | 10c. City, Town or Location<br>Washington   |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br>1017 47th Place NE   |   |   | 10f. Zip Code<br>20019                       |   | 10g. Citizen of What Country?<br>US  |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 2   |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>General acct. supervisor                  |  | 16b. Kind of Business/Industry<br>Federal Govt.   |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Reynolds   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lillian JONES  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Helen A. Reynolds Wife   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1017 47th Place NE 20019 Washington DC 20019   |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lincoln Memorial  |  | Date<br>3-14-97   |  | 20c. Location - City or Town, State<br>Suitland MD               |   |  |
|  | 21. Signature of Funeral Service Licensee<br>▶ Alex S. Pope Jr   |   | 22. Name and Address of Facility<br>2617 Pennsylvania Ave. S.E.<br>Alexander S. Pope Funeral Home   |  |   |  |  |   |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Chronic Obstructive Pulmonary Disease<br>Due to (or as a consequence of):<br>b. Decubitus Ulcers<br>Due to (or as a consequence of):<br>c. Parkinson Disease<br>Due to (or as a consequence of):<br>d. Hypertension |   |   |  |   |  |  |   | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28e. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                     |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br>▶ Frank B. Loggitt, MD  |  |   |   | 29c. License number<br>DC 11835              |   | 29d. Date signed (Month, Day, Year)<br>8/10/97   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Frank B. Loggitt, MD   |  |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 12 1997   |  |   |   | 32. Registrar's Signature<br>John D. Russell |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23b or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1000 91 0000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09362

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |   |  |  |
|---|---|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Julie Elizabeth Shoff</b>  |   |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>12</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1515</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |  | 4c. County of Death<br><b>Harford</b>                                   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-14-9786</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Apr 6 1909</b>                | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                                  |  |
|   | Usual Residence of Decedent   |   |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Harford</b>   |   | 10c. City, Town or Location<br><b>Havre de Grace</b>   |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>415 Market St.</b>   |   |   |   | 10f. Zip Code<br><b>21078</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Melvin Eastridge</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Mary Elizabeth Reynolds</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn E. Cole, Daughter</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>630 Ragan Rd. Conowingo MD 21918</b>   |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Conowingo Baptist Cmty Mar 15 1997</b>                                   |   | Date<br><b>Conowingo MD</b>  |  | 20c. Location - City or Town, State                                     |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Richard L. Joopie</i>   |   |   |   | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home, P.A.<br/>111 S Queen St. Rising Sun MD 21911</b>  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b>                      |   |   |   | Approximate Interval Between Onset and Death<br><b>FEW DAYS</b>  |  |   |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>BOWEL PERFORATION</b>   |   |   |   | Due to (or as a consequence of):<br><b>RENAL FAILURE</b>   |  |   |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>RENAL FAILURE</b>   |   |   |   | Due to (or as a consequence of):<br><b></b> |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>DIABETES</b><br><b>HYPERTENSION.</b>   |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of causa of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>             |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>James M.D.</i>  |   | 29c. License number<br><b>D14544</b>        |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 13, 1997</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>IAN D. SOMERVILLE 400 LEWIS ST. HAVRE DE GRACE MD 21078</b>  |   |   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 14 1997</b>   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09363

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph A. Sipala

2. Date of Death

March 13 1997

Day Year

3. Time of Death  
4:17 am.

4a. Facility Name (If not institution, give street and number)

367 Fletchwood Rd. Apartment 33 A

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

222-07-4404

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 2, 1920

9. Birthplace (State or Foreign Country)

Wilmington Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

ELkton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

367 Fletchwood Rd. Apt. 33A

10f. Zip Code

21921

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Finish Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Frank Sipala

18. Mother's Name (First, Middle, Maiden Surname)

Mary Fontello

19a. Informant's Name/Relationship (Type, Print)

Fran J. Sipala

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

367 Fletchwood Rd. Apt. 33A Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cathedral Cemetery

Date

March 17, 1997

20c. Location - City or Town, State

Wilmington, Delaware

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert T. Jones &amp; Foard, Inc.

122 West Main Street Newark, Delaware 19711

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

e. LUNG CANCER

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D29221 MD  
C10002706 DE

29d. Date signed (Month, Day, Year)

3/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Gary Beste M.D. 313 West Main St. Newark, Delaware 19711

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 09364

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |                          |  |   |  |  |  |
|---|--|--------------------------|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HOMER SMITH</b>  |  |                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 13 1997</b>  |  | 3. TIME OF DEATH<br><b>9:30 p. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-26-7559</b>   |  | 5. SEX<br><b>1 M 2 F</b> |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 10, 1910</b>                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |                          |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Wesleyan Health Care Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Denton</b>                                   |  |
| 9c. COUNTY OF DEATH<br><b>Caroline</b>  |  |                          |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Caroline</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Greensboro</b>  |  |                          |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>   |  | 10e. STREET AND NUMBER<br><b>11946 Greensboro Rd.</b>                                  |  |
| 10f. ZIP CODE<br><b>21639</b>   |  |                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>          |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES  |  |                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 6</b>   |  |                          |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic</b>  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>Caroline Co., MD</b>                               |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Alfred Smith</b>  |  |                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura Spence</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elizabeth K. Smith</b>   |  |                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11946 Greensboro Rd., Greensboro, MD 21639</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  |                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Denton Cemetery 3/17</b>  |  | 20c. LOCATION — City or Town, State<br><b>Denton, MD</b>                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fleegle &amp; Helfenbein Funeral Home Greensboro, MD</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>COPD</b> DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                          |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia, Atrial Fibrillation</b>  |  |                          |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>   |  |                          |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>   |  |                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>   |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  |                          |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |  |                          |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |                          |  | 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |                          |  | 29c. LICENSE NUMBER<br><b>D47492</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>3/14/97</b>                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeffrey Denton, Po Box 122, Goldsboro MD 21636</b>  |  |                          |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 18 '97</b>  |  |                          |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876J

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09365

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARRIE MARIE SPENCE

2. Date of Death

Month Day Year  
03 14 97

3. Time of Death

4:20AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton, Maryland

4c. County of Death

Caroline

5. Social Security Number

216-07-4522

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

01/31/1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

201 Federal St., Apt 58

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Ernest C. Greenly

18. Mother's Name (First, Middle, Maiden Surname)

Laura M. Gottwalls Greenly

19a. Informant's Name/Relationship (Type, Print)

Joan Taylor/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9551 Quail Hollow Dr. (102), St. Michaels, MD 21663

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greensboro Cemetery

Date

3/16

20c. Location - City or Town, State

Greensboro, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle & Helfenbein Funeral Home  
Greensboro, MD 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute renal failure  
Due to (or as a consequence of):b. sepsis  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47534

29d. Date signed (Month, Day, Year)

3/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 18 97

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09366

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |  |   |
|---|--|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Samuel Edward SWORDS                             |   |  |   | 2. Date of Death<br>Month Day Year<br>March 5, 1997 |  | 3. Time of Death<br>8 PM   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital |   |  |   | 4b. City, Town, or Location of Death<br>Hagerstown  |  | 4c. County of Death<br>Washington  |   |
| Funeral<br>Director   | 5. Social Security Number<br>278-18-4879   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>77 Yrs.   | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Dec. 5, 1919  | 9. Birthplace (State or Foreign Country)<br>Ohio  |
|   | Usual Residence of Decedent  |   |  |   |   |  |  |   |
| 10a. State<br>MD  |  | 10b. County<br>Garrett  |  | 10c. City, Town or Location<br>Oakland  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br>968 Hutton RD   |  |   |  | 10f. Zip Code<br>21550  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Ship Fitter  |   | 16b. Kind of Business/Industry<br>Ship Building  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Adam ----- Swords  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Susan ----- Howe   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Arthur W. DeWitt/ Step Son  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>973 Hutton Rd., Oakland MD 21550   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Blooming Rose Cemetery  |  | Date<br>3/9/97  |   | 20c. Location - City or Town, State<br>Friendsville, MD  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Stewart Funeral Home<br>32 S. Second St., Oakland MD 21550  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Myocardial Infarction<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br>30 min  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal failure   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br>D46231   |   | 29d. Date signed (Month, Day, Year)<br>March 6, 1997   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. A. Rai 370 Mill St. Hq. Md.   |  |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>MAR 11 1997  |  |   |  | 32. Registrar's Signature<br>   |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09367  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beulah Winifred Showalter

2. Date of Death

Month Day Year  
MARCH 8 1997

3. Time of Death

2035

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

183-30-5611

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 25, 1911 Pennsylvania

9. Birthplace (State or Foreign Country)

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

PA

10b. County

Somerset

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

R.D. #1, Box 261-P

10f. Zip Code

15558

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Milton Hollada

18. Mother's Name (First, Middle, Maiden Surname)

Olive King

19a. Informant's Name/Relationship (Type, Print)

James L. Shumaker/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

180 Nahstadt Acres Drive, Salisbury, PA 15558

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maple Glen Cem., March 11, 1997

Date

20c. Location - City or Town, State

Fort Hill, PA

21. Signature of Funeral Service Licensee

J. L. Shumaker

22. Name and Address of Facility

Newman Funeral Homes, P.A., P. O. Box 275  
179 Miller St., Grantsville, MD 21536

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiorgan Failure

Due to (or as a consequence of):

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

8 days

c. Coronary Atherosclerotic Vascular Disease Unknown

Due to (or as a consequence of):

d. Hypertension / Hyperlipidemia

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency

Respiratory Insufficiency

Leukopenia. Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. Shumaker

29c. License number

D 41980

29d. Date signed (Month, Day, Year)

MARCH 09 / 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARNOLD VERA MA, MSc. 900 SEASON DRIVE SAC. H. HOSPITAL, CUMBERLAND MD 21502

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

John D. Parker-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09368

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
|---|--|---|---|--|--|--|---|--|---|---|--------|---|---------|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marie Maud Cade Shipman</b>   |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>2</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>11 A.M.</b>                                      |  |   |   |        |   |         |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Garrett County Memorial Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Oakland</b>   |  | 4c. County of Death<br><b>Garrett</b>                                   |  |   |   |        |   |         |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>235-48-4352</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan 20, 1935</b>  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>        |  |   |   |        |   |         |  |  |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>WV</b>  | 10b. County<br><b>Tucker</b>  | 10c. City, Town or Location<br><b>Thomas</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |   |        |   |         |  |  |  |
|   | 10e. Street and Number<br><b>Cortland Acres Nursing Home</b>   |   |   | 10f. Zip Code<br><b>26292</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |   |        |   |         |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |   |   |        |   |         |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 th</b> College (1-4 or 5+) <b></b>   |   | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |   |   |        |   |         |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles W. Cade</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Delia M. Bond</b>  |  |  |   |  |   |   |        |   |         |  |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Maxine Jones/daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Location Rd., St. George, WV 26290</b> |  |  |   |  |   |   |        |   |         |  |  |  |
|   | 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Omega Crematory</b>  |  | Date<br><b>Mar. 3, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Morgantown, WV</b>            |  |   |   |        |   |         |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   | 22. Name and Address of Facility<br><b>Newman Funeral Homes, P.A., P.O. Box 275<br/>179 Miller St., Grantsville, MD 21536</b>              |  |  |   |  |   |   |        |   |         |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Acute renal failure</b><br/>Due to (or as a consequence of):</td> <td>1 week</td> </tr> <tr> <td>b. <b>Chronic renal failure</b><br/>Due to (or as a consequence of):</td> <td>2 years</td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>Acute renal failure</b><br>Due to (or as a consequence of): | 1 week | b. <b>Chronic renal failure</b><br>Due to (or as a consequence of): | 2 years | c.<br>Due to (or as a consequence of): |  | d.<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <b>Acute renal failure</b><br>Due to (or as a consequence of):  | 1 week  |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
|   | b. <b>Chronic renal failure</b><br>Due to (or as a consequence of):  | 2 years   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
|   | c.<br>Due to (or as a consequence of):   |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
|   | d.<br>Due to (or as a consequence of):   |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>endometrial cancer, coronary artery disease with angina</b><br><br><b>past history drug and alcohol abuse</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |   |   |        |   |         |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |   |        |   |         |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br><b>D26650</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 2, 1997</b>  |   |  |   |   |        |   |         |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Margaret Kaiser, M.D., P.O. Box 486, Oakland, MD 21550</b>   |  |   |   |  |  |  |   |  |   |   |        |   |         |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 13 1997</b>   |  |   |   | 32. Registrar's Signature<br>                           |  |  |   |  |   |   |        |   |         |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09369

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |  |   |  |
|---|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ethel Marie Sollers</b>   |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>315P</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>  |   | 4c. County of Death<br><b>Calvert</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218 30 4911</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>August 1 1901</b>  | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b> |  |
|   | Usual Residence of Decedent  |   |   |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Calvert</b>  |   | 10c. City, Town or Location<br><b>Lusby</b>                    |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>1095 Sollars Wharf Road</b>  |  | 10f. Zip Code<br><b>20657</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)   |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>self employed</b>                 |  | 16b. Kind of Business/Industry<br><b>piano teacher</b>   |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Jeremiah Kreider</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lydia Sassaman</b>   |   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carlos Ralon- son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1095 Sollars Wharf Rd, Lusby Maryland 20657</b>  |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Calvary Bible Church Cemetery</b>                                    |  | 20c. Location - City or Town, State<br><b>Lusby Maryland</b>   |   | Date <b>March 17, 1997</b>   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>B. Bausch</b>  |   |   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home PA<br/>4405 Broomes Is. Rd. Port Republic Maryland 20676</b>  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive heart failure</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 month</b> |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pneumonia</b>   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Sylvia Batong</b>   |   | 29c. License number<br><b>D 43306</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>March 15, 1997</b>                                |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Sylvia Batong, M.D. 11845 H.G. Trueman Rd. Lusby Maryland 20657</b>  |  |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 17 1997</b>   |  | 32. Registrar's Signature<br><b>Jelia Davidson-Randall</b>  |   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09370

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>YVONNE B. STERLING  |  | 2. Date of Death<br>Month: 03 Day: 13 Year: 1997  |  | 3. Time of Death<br>12 <sup>00</sup> pm  |
|  | 4a. Facility Name (If not institution, give street and number)<br>McCready Foundation, Inc.   |  | 4b. City, Town, or Location of Death<br>Crisfield   |  | 4c. County of Death<br>Somerset  |
| Funeral<br>Director  | 5. Social Security Number<br>214-26-8284  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>81 Yrs.   | If Under 1 Year<br>Months: Days:               | If Under 24 Hrs.<br>Hours: Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br>July 9, 1915   |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |  |  |
|  | 10a. State<br>MD  | 10b. County<br>SOMERSET  | 10c. City, Town or Location<br>CRISFIELD  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br>26676 Mariners Rd.  |  | 10f. Zip Code<br>21817  |  | 10g. Citizen of What Country?<br>U.S.  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): H. S. Graduate<br>College (1-4 or 5+): - - -      |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Manager  |  | 16b. Kind of Business/Industry<br>Crisfield Carpet Shop   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>William H. Pruitt  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Pearl A. Daugherty   |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br>J. Nelson Sterling (Husband)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>26676 Mariners Rd., Crisfield, MD 21817          |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sunnyridge Memorial Park  |  | 20c. Location - City or Town, State<br>Crisfield, MD   |
|  | 21. Signature of Funeral Service Licensee<br>Robert H. Bradshaw, Jr.  |  | 22. Name and Address of Facility<br>Bradshaw & Sons Funeral Home<br>306 W. Main St. - Crisfield, MD 21817   |  |  |
| Physician<br>/Medical<br>Examiner  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |
|  | e. CONGESTIVE HEART FAILURE<br>Dua to (or as a consequence of):   |  |   |  | Approximate Interval Between Onset and Death<br>2 YRS.   |
|  | b. HYPERTENSION<br>Dua to (or as a consequence of):   |  |   |  | 30 YRS.  |
|  | c.<br>Dua to (or as a consequence of):  |  |   |  |  |
|  | d.<br>Dua to (or as a consequence of):  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MOTOR NEURON DISEASE.<br>OSTEOARTHRITIS.  |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No           |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)                                       |   | 28b. Time of Injury<br>M                       |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |
| 29b. Signature and Title of certifier<br>[Signature]   |   | 29c. License number<br>D51086  |   | 29d. Date signed (Month, Day, Year)<br>3-13-97 |  |
| State<br>Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Thirumaleshwara P. Kanchana, MD 320 W. Main St. Crisfield, Md. 21817  |  |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br>MAR 17 1997  |  | 32. Registrar's Signature<br>Julia [Signature]  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09371

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Percy R. Samuels, Jr.

2. Date of Death  
Month Day Year

March 11, 1997 3:28 P.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-12-4562

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7/14/17

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3363 Blaine St., N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printing Press Operator

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Percy R. Samuels, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alma Barham

19a. Informant's Name/Relationship (Type, Print)

Shawn M. Samuels/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3511 26th Ave., Temple Hills, Md. 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cem.

Date

3/19/97

20c. Location - City or Town, State

Wash., D.C.

21. Signature of Funeral Service Licensee

Mary H. Grato

22. Name and Address of Facility

H.S. Washington & Sons, Inc.  
4925 Burroughs Ave., N.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COAGULOPATHY

Due to (or as a consequence of):

c. END STAGE CIRRHOSIS OF THE LIVER

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

ASCITES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Merlyn Vemury MD

29c. License number

D35791

29d. Date signed (Month, Day, Year)

3/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. VEMURY, MD. 9801 GEORGIA AVE, SUITE 227, SILVER SPRING, MD 20902

31. Date filed (Month, Day, Year)

MAR 14 1997

32. Registrar's Signature

John A. Rucker

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09372

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ESTHER

R.

SAMMANS

2. Date of Death

MARCH

Day

Year

3. Time of Death

5:55 PM

4a. Facility Name (If not institution, give street and number)

SUBURAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

579 07 0114

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4 16 1899

9. Birthplace (State or Foreign Country)

WASH, DC

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5721 GROSVENOR LN.

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ANDREW BANNISTER

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE DAWSON

19a. Informant's Name/Relationship (Type, Print)

DEBRAH MAHONEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3829 HAMILTON ST. #202 HYATTSVILLE MD 20781

20a. Method of Disposition

1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN

Date

3/12/97

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee

Juan Smith

22. Name and Address of Facility

JOHN T. RHINES &amp; CO.

3030-12TH. ST. N.E. WASH DC 20017

23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a.

Due to (or as a consequence of):

b.

Possible Pulmonary Embolism

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

15 days

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dayasharma MD

29c. License number

D41119

29d. Date signed (Month, Day, Year)

MARCH 9, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAYA SHARMA 50 W. EDMONSTON DRIVE #303 Rockville Md 20852

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

John Thompson

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09373

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHESTER BENJAMIN SLAUGHTER, SR.

2. Date of Death  
Month Day Year  
MARCH 05, 19973. Time of Death  
04:58 A.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

291-22-3601

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

JAN. 31, 1928

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3506 ST. JOHN'S PLACE

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

BENJAMIN SLAUGHTER

18. Mother's Name (First, Middle, Surname)

FLORENCE JACKSON

19a. Informant's Name/Relationship (Type, Print)

SARAH BOYD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3506 ST. JOHN'S PLACE LANDOVER, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

3-10-97

20c. Location - City or Town, State

LANDOVER, MARYLAND

21. Signature of Funeral Service Licensee

Juwana Braxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MD  
4308 SUITLAND RD. SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mario F. Golie Jr.

29c. License number

DEPUTY MEDICAL EXAMINER  
D 33954

29d. Date signed (Month, Day, Year)

MARCH 05, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLIE JR. M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State  
Registrar

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

John A. Anderson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2. The first part of the report is a general  
description of the project and its objectives.  
The second part is a detailed description of the  
methodology used in the study.

The third part of the report is a description of the  
results of the study. The fourth part is a  
discussion of the results and their implications.

The fifth part of the report is a conclusion  
and a list of references. The sixth part is an  
appendix containing additional data and figures.

The seventh part of the report is a list of  
figures and tables. The eighth part is a list of  
figures and tables. The ninth part is a list of  
figures and tables.

The tenth part of the report is a list of  
figures and tables. The eleventh part is a list of  
figures and tables. The twelfth part is a list of  
figures and tables.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09374

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Moses E. Sykes

2. Date of Death

March 8, 1997

3. Time of Death

6:25 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George Hospital

4b. City, Town, or Location of Death

Cheverly, Md

4c. County of Death

Prince George

5. Social Security Number

223-96-6714

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 22, 1970

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

302 Taurus Dr.

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Moses L. Sykes

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Barnes

19a. Informant's Name/Relationship (Type, Print)

Mildred Jarrett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37373 Owens Grove Rd. Wakefield, VA 28888

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mars Hill Bapt Ch. Cem.

Date

3/11/97

20c. Location - City or Town, State

Capron, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Central VA Funeral Service  
P.O. Box 26528 Richmond, VA 2326123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Overwhelming pneumococcal septicemia/meningitis

Due to (or as a consequence of):

b. streptococcus pneumonia

Due to (or as a consequence of):

c. Splenectomy

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43662

29d. Date signed (Month, Day, Year)

March 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Boyce, P.G. Hospital 3001 Hospital Drive, Cheverly MD 20785

31. Date filed (Month, Day, Year)

MAR 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

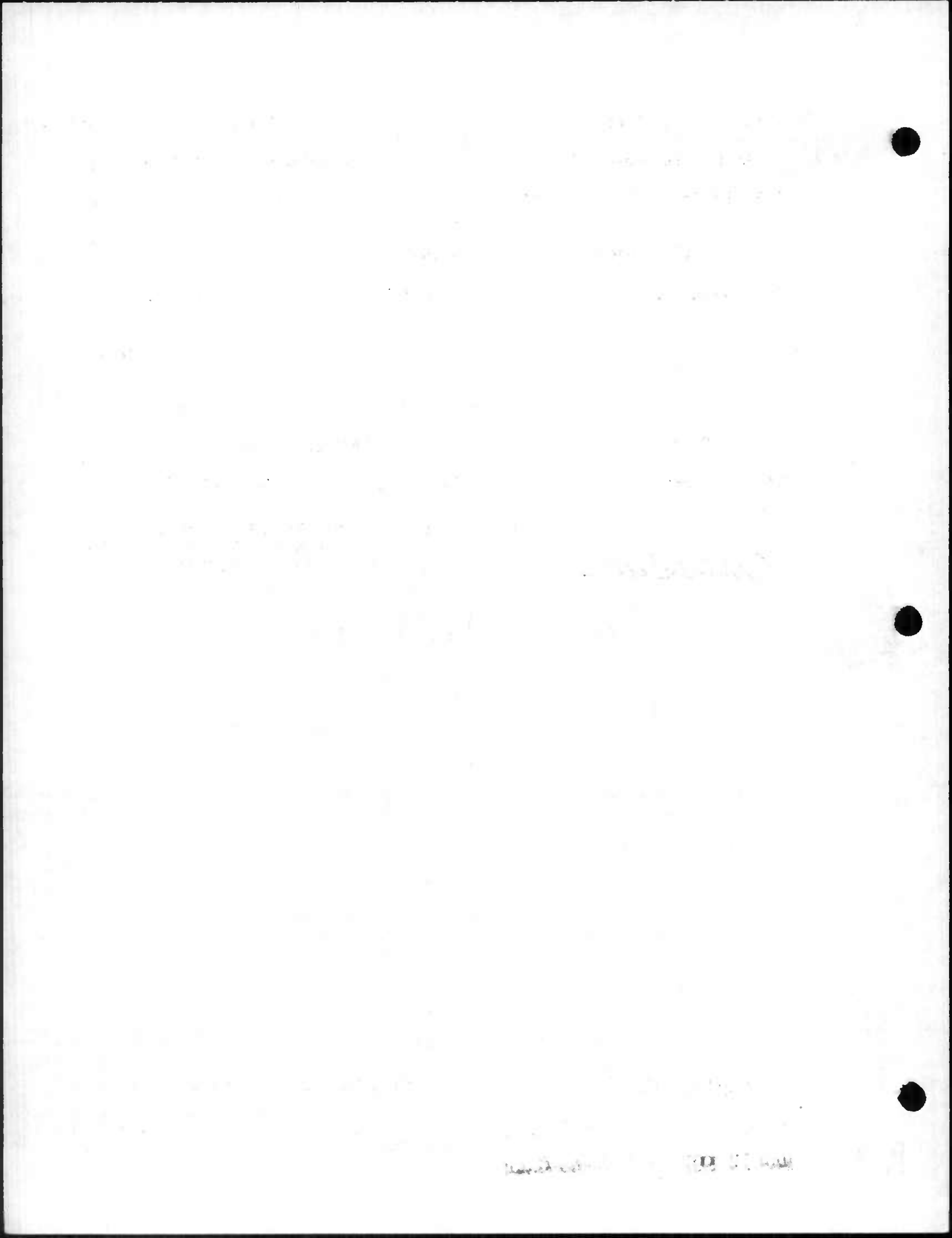
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09375

## Certificate of Death

Reg. No.

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT SMITH</b>  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>09</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>5:50AM</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER E.R.</b> |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>  |                                | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-86-3896</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>03-07-1957</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Capitol Heights</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No               |  |
| 10e. Street and Number<br><b>1106 Dutton Way</b>  |  |   |  | 10f. Zip Code<br><b>20743</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>  |                                | 16b. Kind of Business/Industry<br><b>Private</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Smith, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosemarie Byrd</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Smith, Jr./Brother</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>70 Hanover Parkway, #C-2, Greenbelt, MD 20770</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  | Date<br><b>03/14 1997</b>  |                                | 20c. Location - City or Town, State<br><b>Landover, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Nancy A. Perentis</b>   |  |   |  | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME<br/>7474 Landover Road, Landover, Maryland 20785</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Shotgun wound of Head and Hand</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |                                |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>3-9-97</b>   |  | 28b. Time of Injury<br><b>0120 M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                  |  |
|   |  | 28d. Describe how injury occurred<br><b>Subject shot</b>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>YARD</b>  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1106 Dutton Way 20743</b> |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>J. LARON LOCKE, MD</b>   |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>J. Laron Locke MD</b>   |  |   |  | 29c. License number<br><b>O.C.M.E</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH 10, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |                                |  |  |
| 31. Data filed (Month, Day, Year)<br><b>MAR 13 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>J. Laron Locke</b>   |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09376

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OMETA DOROTHY SMITH

2. Date of Death

Month Day Year  
March 11 1997

3. Time of Death

6:30 pm

4a. Facility Name (If not institution, give street and number)

6915 Hasting Drive

4b. City, Town, or Location of Death

Capital Heights

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

579 40 4673

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
November 26/12

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D. C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1416 Morse Street

10f. Zip Code

2002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Ranto Sellere

18. Mother's Name (First, Middle, Maiden Surname)

Marion Smalls

19a. Informant's Name/Relationship (Type, Print)

Marion Winston

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6915 Hasting Drive Capital Heights

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lincoln Cemetery

Date

3/15/97

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

5538 Marlboro Pike  
Forestville, Maryland 2074723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Atherosclerotic Heart Disease

Approximate  
Interval Between  
Onset and Death

Years

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cervical Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

4502 DC

29d. Date signed (Month, Day, Year)

March 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William R. Frederick, M. D. 106 Irving Street N.W. Washington, D. C. 20010

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John Harrison Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVERETT TAYLOR

2. Date of Death

03

Day

11

Year

97

3. Time of Death

3:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SHOCK TRAUMA/UNIV OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

5. Social Security Number

216-28-2535

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-09-30

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2059 Hopewell Road

10f. Zip Code

21904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking Industry

17. Father's Name (First, Middle, Last)

Walter J. Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Molly D. Jones

19a. Informant's Name/Relationship (Type, Print)

Arvella E. Taylor, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2059 Hopewell Rd. Port Deposit MD 21904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Nottingham Cmty Mar 14 1997 Coloma MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard L. Goodie

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.  
111 S Queen St. Rising Sun MD 21911

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE ORGAN FAILURE

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY

DIABETES MELLITUS

VASCULOPATHY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kevin B. Gerold, D.O.

29c. License number

H31298

29d. Date signed (Month, Day, Year)

03-11-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KEVIN B. GEROLD, D.O. SHOCK TRAUMA, BALTIMORE, MD

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

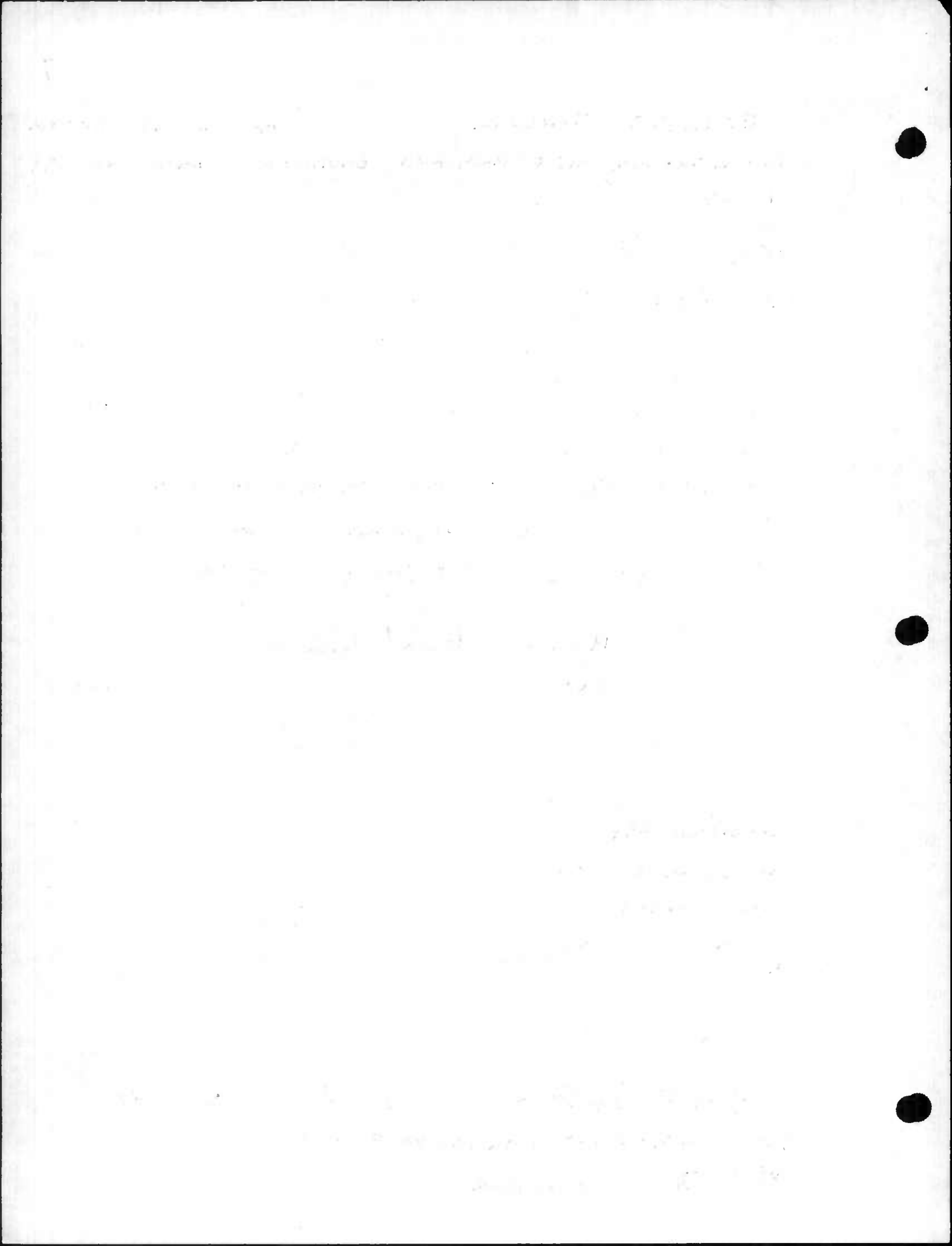
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09378

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |   |  |  |
|--|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Roberta Anne Thrift</b>                                 |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>7</b> Year <b>1997</b> |   | 3. Time of Death<br><b>1:05PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare - The Pines</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Easton</b>                |   | 4c. County of Death<br><b>Talbot</b>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-24-0411</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>July 5, 1922</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                                      |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Caroline</b>                                       |   | 10c. City, Town or Location<br><b>Greensboro</b>           |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>25291 Calvert Drive</b>  |  | 10f. Zip Code<br><b>21639</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                  |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Office Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Church Headquarters</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>James Thomas Hamilton</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mazella Elizabeth Moore</b>  |  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Irving G. Thrift Husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25291 Calvert Drive, Greensboro, Maryland 21639</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Eastern Shore Veterans' Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Beulah, Maryland</b>  |  | 20d. Date<br><b>3/11</b>  |  | 21. Signature of Funeral Service Licensee<br><i>Randolph P. Moore</i>   |  |  |
| 22. Name and Address of Facility<br><b>Moore Funeral Home, P.A.<br/>PO Drawer B, Denton, Maryland 21629</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Renal failure</b><br>Due to (or as a consequence of):<br><b>b. End-stage renal disease</b><br>Due to (or as a consequence of):<br><b>c. Membranoproliferative glomerulonephritis</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>Months</b><br><b>months</b><br><b>months</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                      |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Myeloproliferative disorder</b><br><b>Atrial fibrillation</b><br><b>Congestive heart failure</b> |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>R. P. Moore, MD</i>   |  | 29c. License number<br><b>D25933</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-7-97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MICHAEL CROWLEY MD 508 IDLEWILD AVE EASTON, MD 21601</b>  |  | 31. Data filed (Month, Day, Year)<br><b>MAR 11 '97</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09379

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Thompson G. Turner   |  |   |  | 2. Date of Death<br>Month Day Year<br>March 13, 1997   |  |   |  | 3. Time of Death<br>11:40 am   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Magnolia Gardens Nursing Home  |  |   |  | 4b. City, Town, or Location of Death<br>Lanham   |  |   |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director  | 5. Social Security Number<br>181-01-2782   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 7, 1908 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Beltsville  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>11233 Cedar Lane   |  |   |  | 10f. Zip Code<br>20705   |  | 10g. Citizen of What Country?<br>U.S.A.             |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Builder   |  |   |  | 16b. Kind of Business/Industry<br>Construction   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Thompson G. Turner, Sr.   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elva Draper   |  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Bessie E. Turner - Spouse  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11233 Cedar Lane, Beltsville, Maryland 20705  |  |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery  |  | 20c. Date<br>03/17/97                               |  | 20d. Location - City or Town, State<br>Brentwood, Maryland   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Carlynn Hesch - Healy</i>  |  |   |  | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781  |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC CANCER OF LIVER -<br>Due to (or as a consequence of):<br>b. PRIMARY - UNCERTAIN<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |
| 23c. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |  |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |   |  |  |  |   |  |  |  |
| 28a. Date of Injury (Month, Day, Year)   |  |  |   |  |  |  |   |  |  |  |
| 28b. Time of Injury<br>M   |  |  |   |  |  |  |   |  |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |  |   |  |  |  |
| 28d. Describe how injury occurred  |  |  |   |  |  |  |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  |  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |   |  |  |  |   |  |  |  |
| 29c. License number<br>014799  |  |  |   |  |  |  |   |  |  |  |
| 29d. Date signed (Month, Day, Year)<br>3/13/97   |  |  |   |  |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>K. JOSEPH MATTHEW 6510 Kensington Ave. Riverdale, MD 20737   |  |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 14 1997   |  |  |   |  |  |  |   |  |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene 97 09380

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |  |  |
|--|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Louise Troll</b>  |   |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>1</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2:47 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Corsica Hills Nursing Home</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Centreville</b>   |  | 4c. County of Death<br><b>Queen Annes</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577 50 7452</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 22, 1901</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>Hungary</b>   |  |
|  | Usual Residence of Decedent  |   |   |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County   | 10c. City, Town or Location<br><b>Grasonville</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br><b>1024 Longpoint Road</b>   |   |   | 10f. Zip Code<br><b>21638</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Baker</b>                          |   | 16b. Kind of Business/Industry<br><b>Own Business</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Francis Dettrich</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Schmidt</b>  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Troll Son</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1024 Longpoint Road Grasonville Md. 21638</b> |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery March 4, 1997 Brentwood Maryland</b>           |   | 20c. Location - City or Town, State  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Shannon W. Raming</b>  |   |   | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>                             |  |  |  |  |
|  | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. ALZHEIMERS DISEASE (ADVANCED)</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |   |   |   |  |  | Approximate Interval Between Onset and Death<br><b>3 days</b>  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ALZHEIMERS DISEASE (ADVANCED)</b>   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Alan A. Noble MD</b>   |  |   |   | 29c. License number<br><b>D41587</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/3/97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>A Noble M.D. Corsica Hills Nursing Home, Centreville Maryland</b>   |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 11 1997</b>  |  |   |   | 32. Registrar's Signature<br><b>J. A. Anderson-Randall</b>  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09381

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Elizabeth Williams</b>   |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>14</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1800</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital of Cecil County</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |  | 4c. County of Death<br><b>Cecil</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-30-6058</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 1, 1935</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Elkton</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>1590 Elkton Newark Road</b>  |  | 10f. Zip Code<br><b>21921</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)                           |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Star Services</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Joseph Edward Simperts</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lottie Mae Boyd</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Combs - Daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 772 - Milford, DE 19963</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gilpin Manor Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Elkton, Maryland</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>David S. Hicks</b>  |  |  |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton Street - Elkton, MD 21921-5521</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Carcinoma of Lung</b><br>Due to (or as a consequence of):<br>b. <b>COPD</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  | Approximate Interval Between Onset and Death<br><b>5 months</b><br><b>10 years</b>  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)<br><b>3/17/97</b>  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. Signature and title of certifier<br><b>Jui Chih Hsu MD</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D04823</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>3/17/97</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jui Chih Hsu, MD 223 West main st. Elkton, Md 21921</b>  |  |  |  | 31. Data filed (Month, Day, Year)<br><b>MAR 17 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>Johid Davidson-Randall</b>  |  |  |  | 33. Registrar's Name<br><b>Johid Davidson-Randall</b>   |  |   |  |
|   | 34. Registrar's Title<br><b>Registrar</b>   |  |  |  | 35. Registrar's Address<br><b>4</b>   |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09382

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
|---|---|--|---|--|--|--|---|---|---|----|---------------|--|----|--------------------------------|----|--|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John Harvey Walter</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>15</b> Year <b>97</b>  |  | 3. Time of Death<br><b>0110</b>   |   |   |    |               |  |    |                                |    |  |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |  | 4c. County of Death<br><b>Cecil</b>                                     |   |   |    |               |  |    |                                |    |  |    |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-03-5520</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.                                       | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>August 2 1907</b>          | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |   |    |               |  |    |                                |    |  |    |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Cecil</b>  | 10c. City, Town or Location<br><b>Chesapeake City</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |    |               |  |    |                                |    |  |    |
|   | 10e. Street and Number<br><b>309 Lock St.</b>   |  |   |  | 10f. Zip Code<br><b>21915</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |   |   |    |               |  |    |                                |    |  |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |    |               |  |    |                                |    |  |    |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b>  |  | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Equipment Operator</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>                   |   |   |    |               |  |    |                                |    |  |    |
|   | 17. Father's Name (First, Middle, Last)<br><b>Townsend H. Walter</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Benson</b>   |  |   |   |   |    |               |  |    |                                |    |  |    |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Paul R. Kirk, Stepson</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4707 Forest St. Bristol PA 19007</b>   |  |   |   |   |    |               |  |    |                                |    |  |    |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R A Ferris March 10 1997</b>   |  | Date   |  | 20c. Location - City or Town, State<br><b>West Chester, PA</b>          |   |   |    |               |  |    |                                |    |  |    |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home, P.A.<br/>318 George St. Chesapeake City MD 21915</b>                             |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
|   | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Sepsis</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>7 days</b><br/><b>7 days</b></td> </tr> <tr> <td>b.</td> <td><b>Urinary Tract Infection</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |  |  |  |   |   | Immediate Cause (Final disease or condition resulting in death) | a. | <b>Sepsis</b> | Approximate Interval Between Onset and Death<br><b>7 days</b><br><b>7 days</b> | b. | <b>Urinary Tract Infection</b> | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | <b>Sepsis</b>  | Approximate Interval Between Onset and Death<br><b>7 days</b><br><b>7 days</b>  |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
|   | b.  | <b>Urinary Tract Infection</b>   |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
|   | c.  |  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
|   | d.  |  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>- Pernicious Anemia</b><br><b>- Dementia</b>   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |   |    |               |  |    |                                |    |  |    |
|   |   |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |    |               |  |    |                                |    |  |    |
|   |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |    |               |  |    |                                |    |  |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |    |               |  |    |                                |    |  |    |
|   |   | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |    |               |  |    |                                |    |  |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
|   |   | 29c. License number<br><b>D23322</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/15/97</b>                                  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>S.S. SACHDEV 111 W. HIGH ST ELKTON MD 21921</b>  |   |  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |
| 31. Date filed (Month, Day, Year)<br><b>MAR 18 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |  |   |   |   |    |               |  |    |                                |    |  |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09383

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |                                |  |  |
|---|---|--|---|---|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Florence R. Woodall   |  |   |   | 2. Date of Death<br>Month Day Year<br>March 13, 1997   |                                | 3. Time of Death<br>11:45 pm   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Med Pointe Continuing Care Facility   |  |   |   | 4b. City, Town, or Location of Death<br>Elkton   |                                | 4c. County of Death<br>Cecil   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>219-36-5670  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                  | 7. Age (In yrs. last birthday)<br>85 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>June 21, 1911  | 9. Birthplace (State or Foreign Country)<br>Maryland |
|   | Usual Residence of Decedent   |  |   |   | 10a. State<br>MD   |                                | 10b. County<br>Cecil   |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br>Elkton   |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                | 10e. Street and Number<br>1 Price Drive  |  |
|   | 10f. Zip Code<br>21921  |  |   |   | 10g. Citizen of What Country?<br>USA   |                                | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
|   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>School Teacher  |                                | 16b. Kind of Business/Industry<br>Galena Kent Co. School Dist.   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Scott Rosin  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katie Smith   |                                |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Kate Woodall Alfree (daughter)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>416 Jarman Ave. Galena, MD 21635  |                                |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Silverbrook Crematory |   | 20c. Location - City or Town, State<br>Wilm., DE   |                                | 21. Signature of Funeral Service Licensee<br><i>Nicholas D. Pissell</i>  |  |
|   | 22. Name and Address of Facility<br>McCrery Funeral Homes, Inc.<br>3924 Concord Pike Wilm., DE 19803  |  |   |   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Cerebral Vascular Accident<br>Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                                |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |   |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |                                |  |  |
|   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   | 29b. Signature and title of certifier<br><i>Wallace Obenshain, MD</i>  |                                |  |  |
|   | 29c. License number<br>D07129   |  |   |   | 29d. Date signed (Month, Day, Year)<br>14 March 97   |                                |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Wallace Obenshain, MD, Cecilton, MD 21913   |  |   |   | 31. Date filed (Month, Day, Year)<br>MAR 18 1997   |                                |  |  |
|   | 32. Registrar's Signature<br><i>Julia Davidson-Rondelle</i>   |  |   |   |  |                                |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



97 09384

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Sally WESSEL   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 11 1997   |  | 3. TIME OF DEATH<br>8:00 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>221-24-8264   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 30, 1914   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Wesleyan Nursing Center  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Denton   |  | 9c. COUNTY OF DEATH<br>Caroline   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Caroline  |  | 10c. CITY, TOWN OR LOCATION<br>Denton   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>280 Campground Road  |  |  |  | 10f. ZIP CODE<br>21629  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7<br>College (1-4 or 5+) College  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ruben Buckle  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Emma Cannon Buckle   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Marjorie Bland   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>66 Upland Ave. Dover, Delaware 19901   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greensboro Cemetery 3/14  |  | 20c. LOCATION — City or Town, State<br>Greensboro, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Fleagle-Helfenbein Funeral Home<br>P.O. Box 160 Greensboro, MD 21639  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC LUNG DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>54   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>D35284   |  | 29d. DATE SIGNED (Month, Day, Year)<br>3/13/97  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ANDREW ALLEN MD 920 Market St Denton MD 21629   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>MAR 14 '97  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09385

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lula Pearl WHITE

2. Date of Death

March 4, 1997

3. Time of Death

3:00a.m.

4a. Facility Name (If not institution, give street and number)

Goodwill Mennonite Home

4b. City, Town, or Location of Death

Grantsville

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

218-48-9913

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 24, 1908 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

121 E. Oak St.

10f. Zip Code

21550

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Berkley Paugh

18. Mother's Name (First, Middle, Maiden Surname)

Martha Mae Collins

19a. Informant's Name/Relationship (Type, Print)

William J. White Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 654, Kitzmiller, MD 21538

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oakland Cemetery

Date

3/9/97

20c. Location - City or Town, State

Oakland, Maryland

21. Signature of Funeral Service Licensee

Bradley A. Stewart

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St. Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Occlusive Peripheral Vascular Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteomyelitis right leg with amputation, COPD,  
Old CVA, Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Margaret A. Kaiser MD

29c. License number

D26650

29d. Date signed (Month, Day, Year)

3/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret A. Kaiser MD 13079 Garrett Highway Oakland MD 21550

31. Date filed (Month, Day, Year)

MAR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

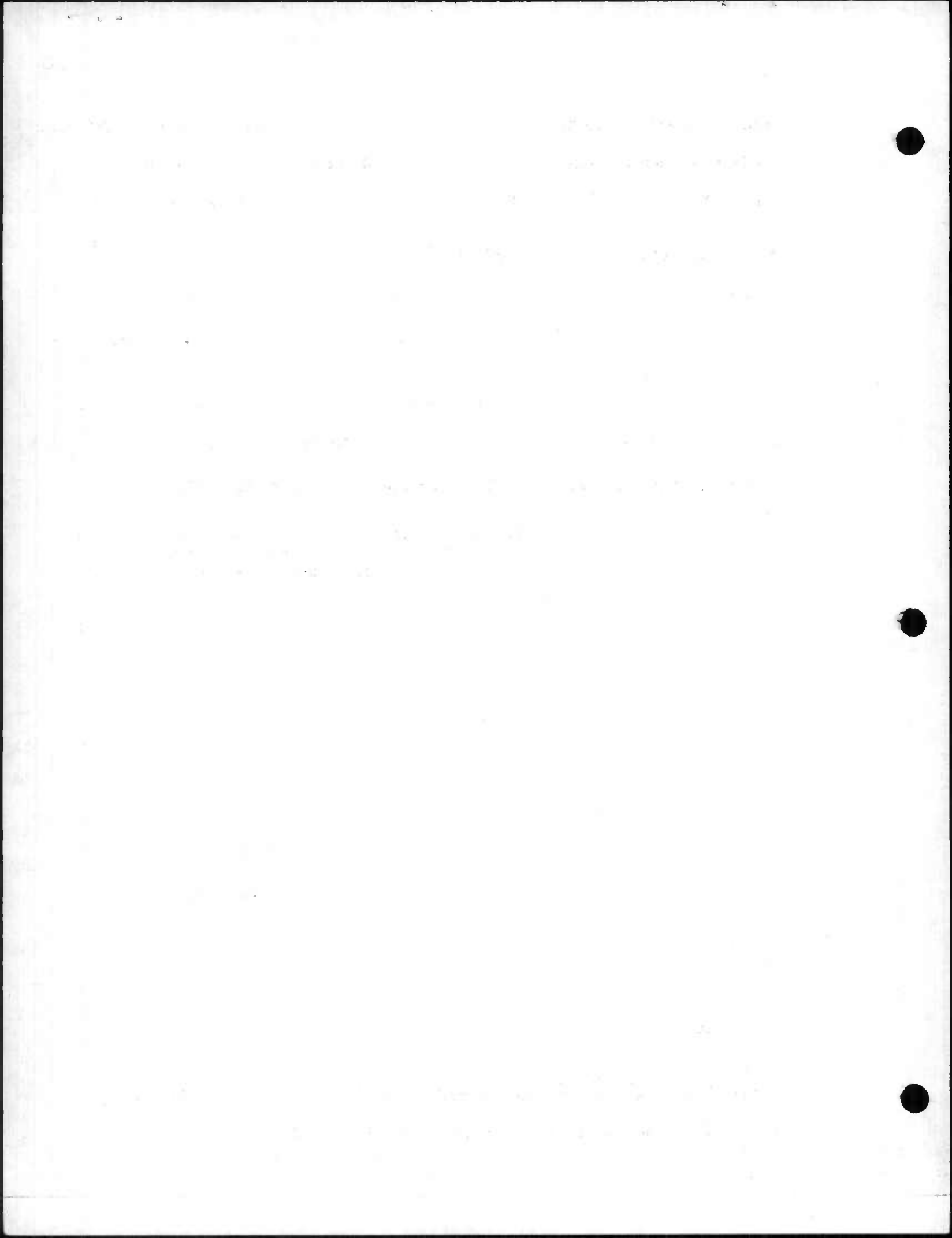
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





97 09386

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Frank Matthew Wojcik   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>March 14, 1997   |  | 3. TIME OF DEATH<br>6:00 AM  |   |
| 4. SOCIAL SECURITY NUMBER<br>205 05 6253   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>84 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan 29, 1913   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>5805 Garden Drive  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Clinton   |   |
| 9c. COUNTY OF DEATH<br>Prince George's   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Prince George's   |   |
| 10c. CITY, TOWN OR LOCATION<br>Clinton   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>5805 Garden Drive  |   |
| 10f. ZIP CODE<br>20735   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Brakeman  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Pennsylvania Railroad  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Matthew Wojcik  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marie Nachman   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Frank Wojcik (SON)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9410 Paul Drive, Clinton Maryland 20735   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Our Lady of Mount Carmel March 18, 1997<br>Shenandoah, Pa   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Lee Funeral Home, Inc 6633<br>Old Alexandria Ferry Road, Clinton, MD 20735   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA<br>b. CORONARY ARTERY DISEASE<br>c.<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br>714v<br>714v  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>R. B. Samlows   |  |  |  | 29c. LICENSE NUMBER<br>D27744  |  | 29d. DATE SIGNED (Month, Day, Year)<br>3.14.97   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>RAJ. SANTANI MD 7131 PISCATAWAY RD CLINTON  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>MAR 18 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Dawson Randall  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09387

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES E. Ward</b>  |   | 2. Date of Death<br>Month <b>March</b> Day <b>15</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>0935</b>  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |   | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-20-2908</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1925</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   |  |   |  |
|  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Somerset</b>  | 10c. City, Town or Location<br><b>Westover</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>7020 Old Westover-Marion Road</b>  |   | 10f. Zip Code<br><b>21871</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korea</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>---</b>                        |   |  |
|  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator</b>   |   | 16b. Kind of Business/Industry<br><b>Paint Brush Mfg.</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edward D. Ward</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen L. Riggins</b>   |   |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Peggy J. Ward (Sister)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4383 Beechwood Place - Crisfield, MD 21817</b>             |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rehobeth Presbyterian Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Rehobeth, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Robert H. Bradshaw</b>  |   | 22. Name and Address of Facility<br><b>Bradshaw &amp; Sons Funeral Home<br/>306 W. Main St. - Crisfield, MD 21817</b>  |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute MI</b>          |   |  |   | Approximate Interval Between Onset and Death<br><b>4 days</b>  |
|  | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a consequence of):<br><b>Congestive heart failure</b>   |  |   |  |
|  |   | Due to (or as a consequence of):  |  |   |  |
|  |   | Due to (or as a consequence of):  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>John McLean</b>   |  |   |  |
| 29c. License number<br><b>D25209</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/15/97</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. John McLean - 106 Milford Street, Salisbury, Md 21801</b>   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 19 1997</b>  |   | 32. Registrar's Signature<br><b>John Davidson</b>   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the significance of the study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09388

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FREDERICK C. WICHT, JR.

2. Date of Death

Month Day Year  
March 15, 1997

3. Time of Death

6:08 AM

4a. Facility Name (If not institution, give street and number)

3330 Sackertown Road

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

099-22-9112

6. Sex

M 2 F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 23, 1930

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3330 Sackertown Road

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5 +

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Dentist

16b. Kind of Business/Industry

Dental

17. Father's Name (First, Middle, Last)

Frederick C. Wicht

18. Mother's Name (First, Middle, Maiden Surname)

Helen Smith

19a. Informant's Name/Relationship (Type, Print)

Sally A. Wicht (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3330 Sackertown Road - Crisfield, MD 21817

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery 3/18/97 Hurlock, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert H. Bradshaw

22. Name and Address of Facility

Bradshaw &amp; Sons Funeral Home

306 W. Main St. - Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Malignant Lymphoma, Advanced 5 yrs  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Oral Candidiasis

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregorio M. Belloso MD

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

3-17-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gregorio M. Belloso, MD - 5302 Chinaberry Drive - Salisbury, MD 21801

31. Date filed (Month, Day, Year)

MAR 19 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended item #26 per physician  
3/14/97 Carroll Co. p.l.c.

State of Maryland / Department of Health and Mental Hygiene

97 09389

## Certificate of Death

Reg. No.

|                                     |  |  |   |                                |  |   |  |   |
|-------------------------------------|--|--|---|--------------------------------|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ricky Edward Windsor</b>  |  |   |                                | 2. Date of Death<br>Month Day Year<br><b>March 12, 1997</b>  |   | 3. Time of Death<br><b>1:35 p.m.</b>   |   |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>10173 Ridgeline Drive</b>   |  |   |                                | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>  |   | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>216-60-3641</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 20, 1952</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|                                     | Usual Residence of Decedent  |  |   |                                |  |   |  |   |
| To Be Completed by Funeral Director | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |                                | 10c. City, Town or Location<br><b>Gaithersburg</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|                                     | 10e. Street and Number<br><b>17739 Larchmont Terrace</b>   |  |   |                                | 10f. Zip Code<br><b>20877</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|                                     | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>landscaper</b>  |                                | 16b. Kind of Business/Industry<br><b>landscape design/ planting</b>  |   |  |   |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Clarence E. Windsor</b>  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma L. Branham</b>  |   |  |   |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Clarence E. Windsor/ father</b>   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3881 Littlestown Pike Westminster, MD 21158</b>  |   |  |   |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation, Inc.</b>  |                                | Date<br><b>3/14/97</b>   |   | 20c. Location - City or Town, State<br><b>Hampstead, MD</b>                                    |   |
|                                     | 21. Signature of Funeral Service Licensee<br><i>Katharine O. Waldmann</i>  |  |   |                                | 22. Name and Address of Facility<br><b>Hartzler Funeral Home<br/>New Windsor, MD</b>   |   |  |   |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Inanition and dehydration</b><br>Due to (or as a consequence of):<br><b>b. Progressive multifocal leukoencephalopathy 22 mos.</b><br>Due to (or as a consequence of):<br><b>c. AIDS</b><br>Due to (or as a consequence of):<br><b>d. HIV infection</b> |  |   |                                |  |   |  |   |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                                |  |   |  |   |
| Physician<br>/Medical<br>Examiner   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |   |  |   |
|                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |                                |  |   |  |   |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Grand mal seizures before PML</b><br><b>Focal seizures</b><br><b>Migraine and other severe headaches</b>  |  |   |                                |  |   |  |   |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Friend's Residence</b> |                                |  |   |  |   |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |  |   |  |   |
|                                     | 29b. Signature and title of certifier<br><i>Katharine Waldmann, M.D.</i>   |  |   |                                | 29c. License number<br><b>D08818</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 13, 1997</b>                                   |   |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Katharine Waldmann, M.D. 2000 Dennis Ave. Silver Spring, MD 20902</b>   |  |   |                                |  |   |  |   |
|                                     | 31. Date filed (Month, Day, Year)<br><b>MAR 14 1997</b>  |  | 32. Registrar's Signature<br><i>John Anderson-Rodell</i>  |                                |  |   |  |   |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09390

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |   |  |   |  |
|---|--|--|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FRANCES WARDRICK</b>                                      |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>13</b> Year <b>1997</b> |   | 3. Time of Death<br><b>5:40AM</b>                        |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>               |   | 4c. County of Death<br><b>Prince George's</b>            |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-40-8559</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>01-04-1941</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>                                 |   | 10c. City, Town or Location<br><b>Lanham</b>             |   |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>8409 Hamlin Street</b>  |   | 10f. Zip Code<br><b>20706</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Keypunch Operator</b>  |  | 16b. Kind of Business/Industry<br><b>Government</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Robert Boone</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Washington</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Wardrick/Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2749 Ordway Street, NW, Washington, D.C. 20008</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>                                  |  | 20c. Location - City or Town, State<br><b>Landover, Maryland</b>                      |  |
| 21. Signature of Funeral Service Licensee<br><b>Nancy A. Perantie</b>   |  | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME</b><br><b>7474 Landover Road, Landover, Maryland 20785</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Septicemia Cardio-pulmonary Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Gangrene of Lower Limbs</b><br>Due to (or as a consequence of):<br>c. <b>Extensive Vascular disease</b><br>Due to (or as a consequence of):<br>d. |   | Approximate Interval Between Onset and Death  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Systemic Lupus Erythematosus</b><br><b>End Stage Kidney Hemodialysis</b><br><b>Advanced Osteodystrophy</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certificate (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Rishpal Singh</b>  |  | 29c. License number<br><b>D17989</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3.13.97</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>RISHPAL SINGH, 7525 GREENWAY CENTER DRIVE GREENBELT MD 20770</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 14 1997</b>  |  | Registrar's Signature<br><b>[Signature]</b>  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09391

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |   |  |
|--|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CARRIE WRIGHT</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 7, 1997</b>   |   | 3. Time of Death<br><b>0920 AM</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BADFORD OAKS AND RETIREMENT CENTER</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>   |   | 4c. County of Death<br><b>PRINCE GEORGES</b>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>237-32-2257</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 8, 1920</b>  | 9. Birthplace (State or Foreign Country)<br><b>VANWYCK, S.C.</b>  |  |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>UPPER MARLBORO</b>   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>3304 GEATON DR.</b>   |   |   |  | 10f. Zip Code<br><b>20772</b>  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                            |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b>  |   | College (1-4 or 5+)   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMSTRESS</b>   |   | 16b. Kind of Business/Industry<br><b>PRIVATE</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>HENRY SPRINGS</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CAME MOBLEY</b>  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>GREGORY WRIGHT / SON</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3304 GEATON DR. UPPER MARLBORO, MARYLAND 20772</b>   |   |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY MEMORIAL PARK</b>  |  | Date<br><b>3/14/97</b>   |   | 20c. Location - City or Town, State<br><b>LANDOVER, MARYLAND</b>                                   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Alexander S. Pope Jr.</b>  |   |   |  | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES<br/>5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747</b>  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>FEW MONTHS</b> |   |   |  |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>RENAL INSUFFICIENCY</b><br><b>ATRIAL FIBRILLATION</b>  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29a. Signature and title of certifier<br><b>Dr. [Signature] ATTENDING</b>   |   | 29c. License number<br><b>D-44436</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 07-97</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ASHVINKUMAR J PATEL 603 POSTOFFICE RD WALDORF MD 20602</b>  |  |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 11 1997</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |   |  |   |  |

4 1/3

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09392

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Deadra E. Williams

2. Date of Death  
Month Day Year

03- 09- 97

3. Time of Death

12:45 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-60-6728

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

February 14, 1945

9. Birthplace (State or Foreign Country)

Wash DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13515 Georgia Avenue #304

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Communications Representative Private

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Luther A. Cary

18. Mother's Name (First, Middle, Maiden Surname)

Helen L. Morton

19a. Informant's Name/Relationship (Type, Print)

Barbara Hamlett/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4873 St. Barnabas Road #1, Temple Hills, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

3/13/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Abdominal Carcinomatosis

Due to (or as a consequence of):

6 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Carcinosarcoma Uterus, Metastatic

Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Venous Thrombosis, Deep

Pulmonary Embolism

Malignant Pleural Effusion

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frank Lin

29c. License number

D43199

29d. Date signed (Month, Day, Year)

March 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank Lin M2 10301 Georgia Avenue #205, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09393

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES L. WILLIAMS

2. Date of Death

March 10, 1997

3. Time of Death

5:00 A.M.

4e. Facility Name (If not institution, give street and number)

12002 Hickory Drive

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

286-12-3602

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 18, 1923

9. Birthplace (State or Foreign Country)

Williamsburg, Ky.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

12002 Hickory Drive

10f. Zip Code

20744

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 8/18/44

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Asbury X Williams

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Scott

19e. Informant's Name/Relationship (Type, Print)

Barbara D. Williams - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12002 Hickory Drive, Fort Washington, MD 20744

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

3/14/97

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute respiratory failure

Due to (or as a consequence of):

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

immed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Stewart III

29c. License number

D19431

29d. Date signed (Month, Day, Year)

3/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank W. Ryan M.D. 11701 Livingstone Rd #203 Ft. Wash MD 20744

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

John T. Stewart III

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 09394

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BANKS

MELVIN

WILLIAMS

2. Date of Death

MARCH

Day

06

Year

1997

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

in rear of 6411 WALKER MILL ROAD

4b. City, Town, or Location of Death

CAPITOL HEIGHTS

4c. County of Death

PRINCE GEORGES

5. Social Security Number

246-44-7192

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 21, 1932

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 34th Place, N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business/Industry

Bill Cairnes Pontiac-Buick

17. Father's Name (First, Middle, Last)

Henry Williams

18. Mother's Name (First, Middle, Maiden Sumama)

Cherry Covan

19a. Informant's Name/Relationship (Type, Print)

Mary M. Williams (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 34th Place, N.E. Washington, D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

National Harmony Memorial Park

Date

3/15/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rottins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ASTHMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

IN VAN

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 07, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 13 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



## Certificate of Death

Reg. No.

|  |   |  |  |  |  |   |  |  |  |
|--|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>STEPHEN ANDREW ZARTLER</b>                 |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>9</b> Year <b>1997</b> |   | 3. Time of Death<br><b>1244p</b>                           |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>471 DR JACK ROAD</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>PORT DEPOSIT</b>          |   | 4c. County of Death<br><b>CECIL</b>                        |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-92-0757</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>18</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>July 9, 1978</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                               |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Cecil</b>  |   | 10c. City, Town or Location<br><b>Port Deposit</b>         |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2063 Red Toad Road</b>  |  | 10f. Zip Code<br><b>21904</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Twelve Years</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>   |  | 16b. Kind of Business/Industry<br><b>Burger King Newark, Delaware</b>  |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John A. Zartler</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Woodward</b>   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John A. Zartler (Father)</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2063 Red Toad Road, Port Deposit, Maryland 21904</b>                                     |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rosebank Cemetery</b>   |  | Date<br><b>3/12/97</b>   |  | 20c. Location - City or Town, State<br><b>Calvert, Maryland</b>                             |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Thomas M. Patterson, Sr.</i>   |   |  |  | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home Perryville, Maryland 21903-0188</b>   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |  |  |  |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  |   |  |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>   |  | 26. Place of Death (Check only one)   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>2-9-97</b>  |  | 28b. Time of Injury<br><b>1238</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>Subject drove car into tree</b>  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>471 Dr. Jack Road</b>   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |   | 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>John A. Zartler MD</i>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 10, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 12 1997</b>  |   | 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |  |  |  |   |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



State of Maryland / Department of Health and Mental Hygiene

## Reg. No.

97 09396

**Division of Vital Records, P.O. Box 68760,**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09397

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |   |   |
|---|---|---|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SUSAN LOUISE ALEXANDER</b>   |   |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>19</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>19:06 PM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>139-60-9254</b>   | 6. Sex<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>23</b> Yrs.  | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>05/28/1973</b>  | 9. Birthplace (State or Foreign Country)<br><b>NJ.</b>                  |
|   | Usual Residence of Decedent   |   |   |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>NJ.</b>  | 10b. County<br><b>Camden</b>  | 10c. City, Town or Location<br><b>Cherry Hill</b>   |  |  | 10d. Inside City Limits<br><b>1</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>103 Fenwick Rd.</b>  |   |   | 10f. Zip Code<br><b>08034</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |
|   | 11. Marital Status<br><b>1</b> <input checked="" type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Dietician</b>                            |  | 16b. Kind of Business/Industry<br><b>Nutrition/Medical</b>   |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Joseph Alexander</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carolyn Welch</b>  |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>William J. Alexander/Father</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>103 Fenwick Rd. Cherry Hill, NJ. 08034</b> |  |   |   |
|   | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cem. Haddonfield Methodist</b>   |  | 20c. Location - City or Town, State<br><b>3/24/97 Haddonfield, NJ.</b>   |   |   |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Sterling Ashton Funeral Home, Inc.<br/>736 Edmondson Ave. Balto., MD. 21228</b>  |  |  |   |   |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>VENTRICULAR FIBRILLATION</b><br/>Due to (or as a consequence of):</p> <p>b. <b>HYPOXIA</b><br/>Due to (or as a consequence of):</p> <p>c. <b>ADULT RESPIRATORY DISTRESS SYNDROME</b><br/>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%;"> <p>Ten minutes</p> <p>Two weeks</p> <p>Three weeks</p> </div> </div> |   |   |  |  |   |   |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |   |
| 23c. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown  |   |   |   |  |  |   |   |
| 24a. Was an autopsy performed?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |   |   |   |  |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |   |   |   |  |  |   |   |
| 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |   |  |  |   |   |
| 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No      |   |
|   |   | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>DAVID E. KANDZARI, MD</b>   |   | 29c. License number<br><b>RES-0000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 19, 1997</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID E. KANDZARI, MD TOWER 110 JOHNS HOPKINS, BALTIMORE, MARYLAND 21287</b>   |   |   |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |   | 32. Registrar's Signature<br>   |   |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital/Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09398

|  |   |   |  |  |   |  |  |   |
|--|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Ernestine Virginia Adkins               |   |  |  | 2. Date of Death<br>Month Day Year<br>March 22, 1997  |  | 3. Time of Death<br>11:30 A.M.                       |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>G.B.M.C. Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Towson  |  | 4c. County of Death<br>Baltimore County              |   |
| Funeral<br>Director  | 5. Social Security Number<br>212-26-0776  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>88 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 26, 1908 |   |
|  | Usual Residence of Decedent   |   | 9. Birthplace (State or Foreign Country)<br>Maryland                           |  | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |
| 10a. State<br>Maryland   |   | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore City  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |
| 10e. Street and Number<br>3819 Bayonne Avenue  |   | 10f. Zip Code<br>21206  |  | 10g. Citizen of What Country?<br>United States   |   |  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                 |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>8th Grade  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Home Maker   |  | 16b. Kind of Business/Industry<br>Own Home   |   |  |  |   |
| 17. Father's Name (First, Middle, Last)<br>George Edward Breyer  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Abigail Unknown Wolfe   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>(Daughter)<br>Catherine Jacqueline Smith   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3819 Bayonne Avenue, Baltimore, Maryland 21206  |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Moreland Memorial Park  |  | 20c. Date<br>3/26/97   |   | 20d. Location - City or Town, State<br>Baltimore, Maryland                                       |  |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>6415 Belair Road<br>John C. Miller, Inc. Baltimore, Maryland-21206   |   |  |  |   |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Cardiopulmonary Arrest</u><br>Due to (or as a consequence of):<br>b. <u>CHE</u><br>Due to (or as a consequence of):<br>c. <u>Aortic Stenosis</u><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CAD, cerebrovascular disease</u>  |   |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  |   |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br>D24569   |  | 29d. Date signed (Month, Day, Year)<br>3/27/97   |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Alan M. Shorofsky 515 Fairmount Ave Towson MD 21286  |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>MAR 28 1997   |   | 32. Registrar's Signature<br>   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09399

|   |   |  |  |   |  |  |  |  |
|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                     | 1. Decedent's Name (First, Middle, Last)<br><b>MARY BROWN</b>   |  |  |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>24</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1:45 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director                                   | 5. Social Security Number<br><b>031-18-7012</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>101</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 1, 1895</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington</b>   |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Edgewater</b>  |  |
| To Be Completed by Funeral Director                   | Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>144 Washington Road</b>   |  | 10f. Zip Code<br><b>21037</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>   |  | 16b. Kind of Business/Industry<br><b>Clothing</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Machado</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Pires</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leonard Pimental - Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1517 Widows Mite, Edgewater, MD 21037</b>  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |   | Date<br><b>3/26</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e.<br>Due to (or as a consequence of):<br><br>f.<br>Due to (or as a consequence of):<br><br>g.<br>Due to (or as a consequence of):<br><br>h.<br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>3 days</b>  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Urosepsis</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>3/24/97</b>   |  |
|   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D38958</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/24/97</b> |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DALJEET SINGH SIDHU, 1413 ANNAPOLIS ROAD #106, ODENTON MD 21113</b> |  | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b> |  | 32. Registrar's Signature<br> |  |  |



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State of Maryland / Department of Health and Mental Hygiene

97 09400

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN

BROWN

2. Date of Death

March 23 1997 5:50 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Church Home Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

216-14-3596

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

July 4, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4505 Parkmont Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

John Unknown Zajdel

18. Mother's Name (First, Middle, Maiden Surname)

Rose Unknown Schepanik

19a. Informant's Name/Relationship (Type, Print)

Virginia M. Harlow/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4505 Parkmont Avenue, Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery 3/26/97

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Guanta R. Thomas

22. Name and Address of Facility

John C. Miller, Inc.  
6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

b. DEMENTIA

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOPOROSIS, ESOPHAGEAL STRICTURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Guanda R. Thomas, MD

29c. License number

D46683

29d. Date signed (Month, Day, Year)

MARCH 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VINICIO HERNANDEZ 100 N. BROADWAY; BALTIMORE, MD 21231

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

U.S.

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D.C.

MEMORANDUM FOR THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

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State of Maryland / Department of Health and Mental Hygiene

97 09401

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BURTON Francis CORSON</b>                           |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:55 A.M.</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>         |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>186-09-9611</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 6. Date of Birth (Month, Day, Year)<br><b>Oct. 28, 1909</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |
|  | Usual Residence of Decedent  |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>183 Hollen Road</b>   |  |   |  | 10f. Zip Code<br><b>21212</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/><br><b>4 years</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Engineer</b>   |   | 16b. Kind of Business/Industry<br><b>Petroleum Distribution</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Alan Corson</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Burton</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Corson (son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>116 Tregarone Road Timonium, Maryland 21093</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Govans Presbyterian Church Cem. 3-29-97</b>  |  | Data   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Home<br/>6500 York Road Baltimore, Maryland 21212</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death                    |
| a. <u>ACUTE MYOCARDIAL INFARCTION</u><br>Due to (or as a consequence of):<br>b. <u>ASCVD</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____   |  |   |  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                               |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                     |  |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D33215</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>03/26/97</b>   |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shirley Richards, M.D. 100 West Road Towson, Maryland 21204</b>   |  |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 09402

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |   |  |  |  |
|--|---|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CHRISTINE A. CERNIGLIA                            |   |  |  | 2. Date of Death<br>Month Day Year<br>MARCH 25, 1997 |  |   |  | 3. Time of Death<br>10:30 AM                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>ANNE ARUNDEL MEDICAL CENTER |   |  |  | 4b. City, Town, or Location of Death<br>ANNAPOLIS    |  |   |  | 4c. County of Death<br>ANNE ARUNDEL                  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-09-1648  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>81 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>NOV 05, 1915 |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND |  |
|  | Usual Residence of Decedent   |   |  |  |  |  |   |  |  |  |
| 10a. State<br>MD   |   | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>BALTIMORE   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>2656 WILKENS AVENUE  |   |   |  | 10f. Zip Code<br>21223   |  |  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                 |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>6TH GRADE  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CAFETERIA WORKER  |  |  |   | 16b. Kind of Business/Industry<br>BALTIMORE CITY SCHOOL SYSTEM                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br>JOSEPH DABKOWSKI  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>CATHERINE MAJEWSKI  |  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>JOSEPH R. CERNIGLIA, SR (SON)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1651 FOOLISH PLEASURE COURT-ANNAPOLIS, MD 21401   |  |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>NEW CATHEDRAL CEMETERY  |  | Date<br>3/31/97  |  | 20c. Location - City or Town, State<br>BALTIMORE                                     |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Jackie D. Shannon</i>  |   |   |  | 22. Name and Address of Facility<br>HUBBARD FUNERAL HOME, INC.<br>4107 WILKENS AVENUE-BALTIMORE, MD 21229  |  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <i>Cardiopulmonary Arrest</i><br>Due to (or as a consequence of):<br>b. <i>Respiratory Arrest</i><br>Due to (or as a consequence of):<br>c. <i>Food Aspiration and tracheal occlusion</i><br>Due to (or as a consequence of):<br>d. <i>multiinfarct Dementia</i> |   |   |  |  |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Smoking in Past 40 pack-years</i><br><i>Hyper tension</i>   |   |   |  |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>John P. Serlemitsos</i> mo   |   | 29c. License number<br>D32654   |  |  |  | 29d. Date signed (Month, Day, Year)<br>March 25, 1997                                |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>John P. Serlemitsos 1509 Ritchie Highway, Arnold, MO 21012</i>  |   |   |  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 28 1997   |   | 32. Registrar's Signature<br><i>John P. Serlemitsos</i>   |  |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

23C  
Does this  
need ME  
signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09403

|   |   |   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|---|---|---|---|--|--|--|--|---|---|------------------------------------|---|------------------------------------|----------------|-----------------------------------|-----------------|------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Florence E. Deems</b>  |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>0245</b>  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |  | 4c. County of Death<br><b>Prince George</b>  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| Funeral<br>Director   | 5. Social Security Number<br><b>097-07-8077</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept. 16, 1913</b>                                | 9. Birthplace (State or Foreign Country)<br><b>New York</b> |   |                                    |   |                                    |                |                                   |                 |                        |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Laurel</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 10e. Street and Number<br><b>14612 Shiloh Court Apt X3</b>  |   |   |  | 10f. Zip Code<br><b>20708</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Lindsey</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Florence A. Bryant</b>   |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert E. Deems/Husband</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14612 Shiloh Court Apt X3, Laurel, MD 20708</b>  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr.</b>   |  | Date<br><b>3/27</b>  |  | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>                                 |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road, Laurel, MD 20707</b>   |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. <b>Cerebrovascular accident</b></td> <td>Approximate Interval Between Onset and Death<br/><b>2 days</b></td> </tr> <tr> <td>b. <b>Congestive heart failure</b></td> <td><b>5 years</b></td> </tr> <tr> <td>c. <b>Coronary artery disease</b></td> <td><b>10 years</b></td> </tr> <tr> <td>d. <b>Hypertension</b></td> <td><b>20 years</b></td> </tr> </table> |   |   |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | e. <b>Cerebrovascular accident</b> | Approximate Interval Between Onset and Death<br><b>2 days</b> | b. <b>Congestive heart failure</b> | <b>5 years</b> | c. <b>Coronary artery disease</b> | <b>10 years</b> | d. <b>Hypertension</b> |
| Immediate Cause (Final disease or condition resulting in death)   | e. <b>Cerebrovascular accident</b>  | Approximate Interval Between Onset and Death<br><b>2 days</b>   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | b. <b>Congestive heart failure</b>  | <b>5 years</b>  |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | c. <b>Coronary artery disease</b>   | <b>10 years</b>   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   | d. <b>Hypertension</b>  | <b>20 years</b>   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>043237</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>3-27-97</b>  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Armstrongs 14201 Laurel PK. Dr. #102 Laurel MD 20707</b>  |   |   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |   | 32. Registrar's Signature<br>   |   |  |  |  |  |   |   |                                    |   |                                    |                |                                   |                 |                        |

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

97 09404

ITEM: 17 per TRACEY BAKER 3-28-97 eoh 6-14 Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |   |  |
|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><u>Ney Kura Dorsey</u>                                  |   |  |   | 2. Date of Death<br>Month <u>February</u> Day <u>19</u> Year <u>1997</u>   |  | 3. Time of Death<br><u>0515 AM</u>                              |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><u>The Johns Hopkins Hospital</u> |   |  |   | 4b. City, Town, or Location of Death<br><u>Baltimore City</u>  |  | 4c. County of Death<br><u>unla</u>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>none</u>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>17</u> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>FEB. 02, 1997</u>     | 9. Birthplace (State or Foreign Country)<br><u>BALTIMORE, MD</u>   |
|  | 10e. State<br><u>MD</u>   |   |  |   | 10b. County<br><u>n/a</u>  |  | 10c. City, Town or Location<br><u>BALTIMORE</u>                 |  |
| To Be Completed by Funeral Director                                  |   | 10e. Street and Number<br><u>921 Jack Street</u>  |  |   | 10f. Zip Code<br><u>21225</u>  |  | 10g. Citizen of What Country?<br><u>UNITED STATES</u>           |  |
|  |   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>  |
|  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>none</u> College (1-4 or 5+) <u>---</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>BABY</u>  |  | 16b. Kind of Business/Industry<br><u>n/a</u>   |   |  |
|  |   | 17. Father's Name (First, Middle, Last)<br><u>LEONARD DORSEY JR.</u>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>DIONE RODMAN</u>   |  |   |  |
|  |   | 19a. Informant's Name/Relationship (Type, Print)<br><u>CRYSTAL HENDERSON</u>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>921 JACK STREET, BALTIMORE, MD</u> |  |   |  |
|  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>CEDAR HILL CEMETERY</u>  |  | 20c. Location - City or Town, State<br><u>2-24 ANNE ARUNDEL co, MD</u>   |   |  |
|  |   | 21. Signature of Funeral Service Licensee<br><u>Bernard D Johnson</u>   |  |   | 22. Name and Address of Facility<br><u>WM. C. MARCH FH.-1101 E. NORTH AVENUE</u>   |  |   |  |
|  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><u>Hepatic Failure</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u>1 week</u> |  |   |  |  |   |  |
| Physician<br>/Medical<br>Examiner                                    |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| Medical Certification: To Be Completed by Physician/Medical Examiner |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
|  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><u>M</u>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
|  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |  |
|  |   | 29b. Signature and title of certifier<br><u>Diane C Lipscomb MD</u>   |  |   | 29c. License number<br><u>M5637</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>February 19, 1997</u> |  |
|  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Diane C Lipscomb The Johns Hopkins Hospital Baltimore MD</u>   |  |   |  |  |   |  |
| State<br>Registrar   |   | 31. Date filed (Month, Day, Year)<br><u>MAR 28 1997</u>   |  |   | 32. Registrar's Signature<br><u>[Signature]</u>  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baby  
is 23a  
acceptable

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland, Department of Health and Mental Hygiene  
 Items: 23 part I, 27, 28a-F per MD G-748 4/1/97  
 ITEM #9, 17 & 18 PER F.H. FLM#G745 3/28/97 J.R.R.

97 09405

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES DAWSON</b>  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 21, 1997</b>      |  | 3. Time of Death<br><b>2304PM</b>            |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>J.H.H. BAYVIEW MEDICAL CENTER</b> |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>    |  | 4c. County of Death<br><b>N/A</b>            |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-50-8498</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.                 | If Under 1 Year<br>Months Days<br><b>1 1</b>   | If Under 24 Hrs.<br>Hours Min.<br><b>1 1</b> |
|  | 8. Date of Birth (Month, Day, Year)<br><b>October 25, 1938</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>WEST VIRGINIA</b> |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   | 10e. Street and Number<br><b>312 S. WOLFE STREET</b>             |  |  |
| 10f. Zip Code<br><b>21231</b>  |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>WELDER</b>   |  |
| 16b. Kind of Business/Industry<br><b>COPPERFELD CO.</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>GEORGE DEWEY DAWSON</b>   |  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DORO SODA BELLE MOORE</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DOLORES DAWSON/WIFE</b>  |  |  |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>312 S. Wolfe Street, Baltimore, Maryland 21231</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Stanislaus Cemetery 3/26/97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Lilly &amp; Zeiler Inc. 1901 Eastern Avenue/21231</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATED BY RIGHT HEMOTHORAX</b><br><b>NEPHROSTOMY TUBE PLACEMENT WITH INTERCOSTAL ARTERY LACERATION</b>   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>3/21/97</b>  |  | 28b. Time of Injury<br><b>P. M.</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred<br><b>INTERCOSTAL ARTERY LACERATED DURING PROCEDURE</b>   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>BAYVIEW/HOPKINS MEDICAL CENTER, BALTIMORE CITY, MD</b>  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>MARCH 22, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09406

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH H</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>24</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>11:56 PM</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL Hospital Assn GLEN BURNIE</b>   |  | 4b. City, Town, or Location of Death<br><b>ANNE ARUNDEL</b>   |  | 4c. County of Death<br><b>MARYLAND</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-26-5419</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.  | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>FEB 18 1933</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  | 10c. City, Town or Location   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10a. State<br><b>MARYLAND</b>  | 10b. County<br><b>N/A</b>  | <b>BALTIMORE CITY</b>   |  |  |
|   | 10e. Street and Number<br><b>1246 YOUNG COURT</b>  |  | 10f. Zip Code<br><b>21202</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+)   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HEALTH CARE WORKER</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>OSCAR WHITE</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BEATRICE WHITE</b>  |  | 16b. Kind of Business/Industry<br><b>HEALTH</b>  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kevin Dargan/Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3103 Ashton Court, Abington, Maryland 21009</b>   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Hani G. Close</b>  |  | 22. Name and Address of Facility<br><b>WILLIAM C. BROWN COMMUNITY F/H<br/>1206 W. NORTH AVENUE</b>  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br><b>SARCOIDOSIS</b><br>Due to (or as a consequence of):  |  |   |  | Approximate Interval Between Onset and Death<br><b>18 months</b>   |
|   | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |  |   |  |  |
|   | Due to (or as a consequence of):   |  |   |  |  |
|   | Due to (or as a consequence of):   |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>W. D. ... MD</b>  |  | 29c. License number<br><b>RES-000</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>WILLIAM QUEALE 1000 EAST ENGLED ST. BALTIMORE, MD 21202</b>  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>                   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



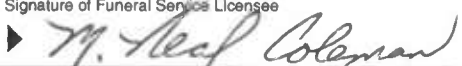

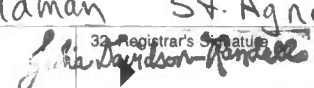
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09407

|  |   |  |   |  |   |   |   |  |
|--|---|--|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGIL WILLIAM EASTON JR</b>                 |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>27</b> Year <b>1997</b> |   | 3. Time of Death<br><b>11:48 AM</b>                       |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>ST. AGNES HOSPITAL</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>              |   | 4c. County of Death<br><b>N/A</b>                         |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-42-2645</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>AUG 6, 1944</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                 |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>                                       |   | 10c. City, Town or Location<br><b>BALTIMORE</b>           |  |
| Usual Residence of Decedent  |   |  |   |  |   |   |   |  |
| 10a. State<br><b>MD</b>  |   |  | 10b. County<br><b>BALTIMORE</b>   |  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 10e. Street and Number<br><b>4401 HILLSIDE AVENUE</b>   |  |   | 10f. Zip Code<br><b>21229</b>   |   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                 |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b><br>College (1-4 or 5+) <b>Collage (1-4 or 5+)</b> |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SIGN CHANGER</b>   |   |  | 16b. Kind of Business/Industry<br><b>SIGN MANUFACTURING</b>   |  |   | 17. Father's Name (First, Middle, Last)<br><b>VIRGIL WILLIAM EASTON, SR.</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MILDRED GRAHAM</b>   |   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY (DOTTIE) EASTON (WIFE)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4401 HILLSIDE AVENUE - BALTIMORE, MD 21229</b>                |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CRESTLAWN GARDENS OF MEMORIES</b>  |  |   | 20c. Location - City or Town, State<br><b>3/31/97 BALTIMORE</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>  |  |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic cardiovascular heart disease</b><br>Due to (or as a consequence of):<br>b. <b>Hyperlipidemia</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |  |   |  |   |   |   |  |
| 23b. Did tobacco use contribute to the causa of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)   |  |   | 28b. Time of Injury<br><b>M</b>   |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 28d. Describe how injury occurred   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |
| 29b. Signature and title of certifier<br><br><b>Isadore A. Feldman, MD</b>  |   |  | 29c. License number<br><b>D20676</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>March 27, 1997</b>  |   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Isadore A. Feldman St. Agnes Hospital 900 South Caton Avenue Baltimore.</b>   |   |  |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |   |  |   |  |   |   |   |  |
| 32. Registrar's Signature<br>   |   |  |   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09408

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |   |  |
|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN EIDEN</b>   |   |  |  | 2. Date of Death<br>Month <b>3</b> Day <b>24</b> Year <b>97</b>  |  | 3. Time of Death<br><b>4:30 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>MD</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>232-20-4012</b>   |   | 6. Sex<br><b>M</b> <input type="checkbox"/> F <input type="checkbox"/>   |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>7-29-19</b>                   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>UNK</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>1305 James Street</b>   |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:          |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNK</b> College (1-4 or 5+) <b>NA</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>UNK</b>                                    |  | 16b. Kind of Business/Industry<br><b>UNK</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>UNK</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNK</b>  |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Arthur L. Drager, Guardian</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 South Light Street Baltimore, MD 21202 Suite 510</b> |  |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion</b>  |  | 20c. Date<br><b>3-28-97</b>  |  | 20d. Location - City or Town, State<br><b>LANSDOWNE, MD</b>             |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>ALBERT P. WYLYCZKA PA<br/>638 N. Gilman Street Baltimore, MD 21217</b>  |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. large hemispheric stroke</b><br>Due to (or as a consequence of):<br><b>b. not known</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>3/1/97.</b>          |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                    |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Dr. Castillo, MD</b>  |  | 29c. License number<br><b>UMMS-8664</b>                                      |  | 29d. Date signed (Month, Day, Year)<br><b>3/24/97.</b>                           |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CARMEN CASTRILLO, MD - UNIVERSITY HOSPITAL - NEUROLOGY DEPT.</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



**Baltimore, Maryland 21215-0020**

**Physician or Attending Physician:** The law requires that the death certificate be examined and signed by a physician or attending physician within 72 hours after death.

**Director:** After this certificate has been signed by the attending physician and the medical examiner, the certificate must be filed with the Bureau of Health. It is then by the funeral director, page 2 should be detached for use as the burial certificate.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Anna Jane Fletcher</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>20</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1435</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>  |  |
| 5. Social Security Number<br><b>220-24-5777</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>July 25, 1928</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Little Orleans</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>11704 Price Road, N.E.</b>   |  | 10f. Zip Code<br><b>21766</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cleaner</b>   |  | 16b. Kind of Business/Industry<br><b>Clothing Manufacture</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Samuel Albert Hollenbaugh</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ann Jane Piper</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Allan F. Fletcher/Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11704 Price Road, N.E., Little Orleans, MD 21766</b>  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Price-Weslyan Mem.Cem.</b>   |  | 20c. Location - City or Town, State<br><b>3/23/97 Little Orleans, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Grove Funeral Home, P.A.<br/>P.O. Box 368 Hancock, MD 21750</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Hypertic Encephalopathy</b><br>Due to (or as a consequence of):<br><b>Cancer</b><br><br><b>4 wk.</b><br><b>20 yr.</b> |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes</b><br><b>Hypertension</b>  |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br> <b>MD</b>  |  |
| 29c. License number<br><b>D12532</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>George Breza MD 912 Seton Drive Cumberland MD 21502</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |  | 32. Registrar's Signature<br>  |  |   |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09410

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FLORA GAMBRELL

2. Date of Death

MARCH 22, 1997

3. Time of Death

9:00am

4a. Facility Name (If not institution, give street and number)

6401 LOCH RAVEN BLVD APT 235

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

Funeral  
Director

5. Social Security Number

213-20-9306

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB 16 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
CITY

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6401 LOCH RAVEN BLVD APT 235

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MACHINE OPERATOR

16b. Kind of Business/Industry

PAPER FACTORY

17. Father's Name (First, Middle, Last)

JOHN EASTER

18. Mother's Name (First, Middle, Maiden Surname)

FLORA COLBURN

19a. Informant's Name/Relationship (Type, Print)

EARL GAMBRELL/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box A-3 E875 Woodchuck Lane Millsboro, DE 19966

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MORELAND MEMORIAL

Date

Mar 25

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Elizabeth A. Selinski

22. Name and Address of Facility

LILLY &amp; ZEILER, INC. FUNERAL HOME

700 SOUTH CONKLING STREET BALTIMORE, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Minutes

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Marc I. Leavey MD

29c. License number

D. 17041

29d. Date signed (Month, Day, Year)

March 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marc I. Leavey MD, 7600 Osler Drive, Suite 315, Baltimore MD 21204

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transferState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

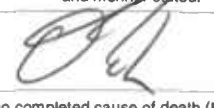
State of Maryland / Department of Health and Mental Hygiene

97 09411

ITEM: 10f per DR. G-745 3-28-97 eoh

## Certificate of Death

Reg. No.

|   |   |  |   |                                |  |
|---|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS</b>   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>22</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>5:11 P.M.</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-25-6543</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 13, 1948</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10a. State<br><b>MD</b>   |                                |  |
|   | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Laurel</b>  |                                |  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |
|   | 10e. Street and Number<br><b>10616 Whiterock Court</b>  |  | 10f. Zip Code<br><b>20723</b><br><b>20707</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Jockey Agent</b>                      |                                | 16b. Kind of Business/Industry<br><b>Horse Racing</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles M. Hauer</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy V. Gowl</b>   |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Terri Kucharski/Sister</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8709 Fowler Avenue, Baltimore, Maryland 21234</b> |                                |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr. 3/24</b>  |                                | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.</b><br><b>7601 Sandy Spring Road, Laurel, Maryland 20707</b>                          |                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.<br><b>Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):           |   |  |   |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |   |                                |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |                                |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |   |  |   |                                |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |   |                                |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |   |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |                                |  |
| 28d. Describe how injury occurred   |   |  |   |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |                                |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |                                |  |
| 29b. Signature and title of certifier<br>  |   |  |   |                                |  |
| 29c. License number<br><b>O.C.M.E.</b>  |   |  |   |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>MARCH 23, 1997</b>  |   |  |   |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |   |  |   |                                |  |
| 32. Registrar's Signature<br>  |   |  |   |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09412

|  |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|--|---|--|--|--|---|--|---|---|---|------------------------------------|---|----------------------------------|--|---------------------------------------|------------|----------------------------------|--|--|--|----------------|----------------------------------|--|----|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Paul Klein Harvey</b>                                    |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>22</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:02PM</b>                                       |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |  | 4c. County of Death<br><b>Howard</b>                                    |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-36-4119</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>June 4, 1941</b>              | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b> |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|  | Usual Residence of Decedent   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Highland</b>   |   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 10e. Street and Number<br><b>7617 Green Dell Lane</b>  |   |  |  | 10f. Zip Code<br><b>20777</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No <b>1959</b><br>If Yes, Give Year or Dates: <b>1964</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner/President</b>                    |   | 16b. Kind of Business/Industry<br><b>Heating &amp; Air Cond. Co.</b>         |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Moses Howell Harvey</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Klein</b>  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sandra L. Harvey/Wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7617 Green Dell Lane, Highland, Maryland 20777</b> |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Linthicum Chapel Cemetery 3/25</b>                |  | Date<br><b>3/25</b>   |  | 20c. Location - City or Town, State<br><b>Clarksville, MD</b>           |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.</b><br><b>7601 Sandy Spring Road, Laurel, Maryland 20707</b>                           |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Ventricular fibrillation</b></td> <td>Approximate Interval Between Onset and Death<br/><b>20 min</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Acute Myocardial Infarction</b></td> <td><b>1 H</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. <b>Atherosclerotic Cardiovascular Disease</b></td> <td><b>7 years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table> |   |  |  |  |   |  |   |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>Ventricular fibrillation</b> | Approximate Interval Between Onset and Death<br><b>20 min</b> | Due to (or as a consequence of): |  | b. <b>Acute Myocardial Infarction</b> | <b>1 H</b> | Due to (or as a consequence of): |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. <b>Atherosclerotic Cardiovascular Disease</b> | <b>7 years</b> | Due to (or as a consequence of): |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Ventricular fibrillation</b>  | Approximate Interval Between Onset and Death<br><b>20 min</b>  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|  | Due to (or as a consequence of):  |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|  | b. <b>Acute Myocardial Infarction</b>   | <b>1 H</b>   |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|  | Due to (or as a consequence of):  |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c. <b>Atherosclerotic Cardiovascular Disease</b>  | <b>7 years</b>   |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|  | Due to (or as a consequence of):  |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| d.   |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                             |   | 28d. Describe how injury occurred                                 |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 29b. Signature and title of certifier<br>  |   |  |  | 29c. License number<br><b>D31473</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 27, 1997</b>                 |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PATRICIA A. TOXE, MD, 4565 Hemlock Lane Way Ellicott City MD 21042</b>  |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |   |  |  |  |   |  |   |   |   |                                    |   |                                  |  |                                       |            |                                  |  |  |  |                |                                  |  |    |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 24a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09413

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN F. HADYNSKI

2. Date of Death

March 24 1997

3. Time of Death

9 a.m.

4a. Facility Name (If not institution, give street and number)

3239 FAIT AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-10-2281

6. Sex

M 2 F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12/4/1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

3239 FAIT AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

XX Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PAYROLL MANAGER

16b. Kind of Business/Industry

CATON RAILROAD

17. Father's Name (First, Middle, Last)

ALEXANDER HADYNSKI

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE POLEK

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH KLEINSCHMIDT/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6123 MARLORA ROAD, BALTIMORE, MARYLAND 21239

20a. Method of Disposition

1X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. STANISLAUS CEMETERY 3/27/97

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY &amp; ZEILER INC. 700 S. CONKLING ST. / 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer of the Liver

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 6 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

211150

29d. Date signed (Month, Day, Year)

3/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. TORRES MD 445 S. ELLWOOD AVE, BALTO, MD 21224

31. Date filed (Month, Day, Year)

MAR 28 1997

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09414

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |  |  |   |  |
|--|---|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Atwood H. Hargrove  |  |   |   | 2. Date of Death<br>Month 3 Day 26 Year 97   |  | 3. Time of Death<br>0530                             |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>University of Maryland  |  |   |   | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>N/A                           |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>237-10-4836  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>80 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birth (Month, Day, Year)<br>JAN 7, 1917   |  | 9. Birthplace (State or Foreign Country)<br>NC  |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  |  | 10b. County<br>Baltimore  |   | 10c. City, Town or Location<br>Reisterstown  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br>307 Highmeadow Road   |  |   |   | 10f. Zip Code<br>21136   |  | 10g. Citizen of What Country?<br>USA                 |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Electronics Engineer                     |   |  | 16b. Kind of Business/Industry<br>Bendix |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Owen Edward Hargrove   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katherine Britt   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Linda Hargrove/Daughter   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13909 Manor Rd. Baldwin, MD 21013   |  |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.   |   | Data<br>3/27/97  |  | 20c. Location - City or Town, State<br>Baltimore, MD |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>Edward Gregorich   |  |   |   | 22. Name and Address of Facility<br>Cremation Society of Maryland<br>299 Frederick Rd. Baltimore, MD 21228   |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Left Temporal - Parietal Intra Cranial Hemorrhage 8 days<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |  |  |  |   | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                 |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>Dr. Cel M.D.  |   |  |   |   | 29c. License number<br>P10519  |  |  | 29d. Date signed (Month, Day, Year)<br>3/26/97   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David Cuellar 22 South Greene Street   |   |  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAR 28 1997   |   |  |   | 32. Registrar's Signature<br>John Davidson-Randall  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09415

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SARAH JONES</b>   |   |   | 2. Date of Death<br>Month <b>03</b> Day <b>26</b> Year <b>97</b>   |  | 3. Time of Death<br><b>9:10</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PIKESVILLE NURSING CENTER</b>   |   |   | 4b. City, Town, or Location of Death<br><b>PIKESVILLE</b>  |  | 4c. County of Death<br><b>MD</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-40-5445</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>9/19/05</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Pikesville</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>14 Chudleigh Court</b>  |   |   | 10f. Zip Code<br><b>21208</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>   |   | College (1-4 or 5+) <b>BS Degree</b>  |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |  | 16b. Kind of Business/Industry<br><b>School</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Augustus Smallwood</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Mc Gruder</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Roberta S. Ross - Niece</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 Chudleigh Court Pikesville MD 21208</b> |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>3-31-97 Randallstown, MD</b>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |   |   | 22. Name and Address of Facility<br><b>March 15, 1997<br/>4300 Wabash Avenue Baltimore MD 21215</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Cancer to the Brain</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |   |   |  |  |  | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>[Signature] MD</b>  |   | 29c. License number<br><b>D47683</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/27/97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Raymond Miller 7220 Park Heights Ave, Baltimore MD</b>   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  |   |   |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09416

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Knight

2. Date of Death

Month  
MarchDay  
24Year  
1997

3. Time of Death

9:40 PM

4a. Facility Name (If not institution, give street and number)

Villa St. Michael 4800 Seton Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

Funeral  
Director

5. Social Security Number

220-84-8097

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
2-2-1924

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7903 Brookford Circle

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
2nd gradeCollege (1-4 or 5+)  
NA16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Norris Knight

18. Mother's Name (First, Middle, Maiden Surname)

Violet Crafton

19a. Informant's Name/Relationship (Type, Print)

Esther Harcum - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7903 Brookford Circle Pikesville, Md 21208

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Data

3-26-97

20c. Location - City or Town, State

Catonsville, Md

21. Signature of Funeral Service Licensee

W. E. Edmond

22. Name and Address of Facility

March F. Hill West  
4300 Wabash Avenue Balt, Md 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Urinary tract infection

Due to (or as a consequence of):

b. urinary outlet obstruction

Due to (or as a consequence of):

c. urethral stricture / prostatic enlargement

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV(+), AIDS

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office-  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Wanda S. Clemmons MD

29c. License number

D35674

29d. Date signed (Month, Day, Year)

March 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wanda S. Clemmons MD 4820 Seton Drive Suite A, Balt Md 21215

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09417

ITEM#5 FILM#G745 3/28/97 PER F.H. J.A,

Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Josephine Kanyuck

2. Date of Death

March 25 1997

3. Time of Death

0910

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

CITY

5. Social Security Number

068-09-3452

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 15, 1913

9. Birthplace (State or Foreign Country)

P.A. Md.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7615 POPLAR AVE.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSE WIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH BUJNY

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

JOSEPH KANYUCK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7615 POPLAR AVE, BALTIMORE, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

OAK LAWN

Date

MAR. 27 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHARLES S. ZEILER AND SON, INC.  
6324 EASTERN AVE, BALTIMORE, MD 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. intracerebral hemorrhage  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

4 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

aspiration pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] Neurology Resident

29c. License number

98202

29d. Date signed (Month, Day, Year)

March 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isaac Silverman Pathology - 600 N. Wolfe St. - Baltimore, MD 21287

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Informant: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09418

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

June Rae Krapf

2. Date of Death

March 27, 1997

3. Time of Death

5:25 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

492-16-2025

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 21, 1921

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2680 Cunningham Hole Rd.

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Everett Kite

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Mercer

19a. Informant's Name/Relationship (Type, Print)

Harry J. Krapf/ Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2680 Cunningham Hole Rd. Ann. Md. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

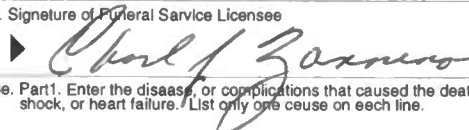
Arlington National

4-2-97

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hardesty Funeral Home P.A.  
12 Ridgely Avenue Ann. Md. 21401

23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ruptured abdominal aortic aneurysm

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 24804

29d. Date signed (Month, Day, Year)

3-27-97

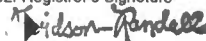
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert T. Peterson M.D. FRANKLIN + Cathedral St. Ann. Md 21401

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09419

Reg. No.

|  |   |  |   |                                |   |
|--|---|--|---|--------------------------------|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>MORRIS</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>04:50 pm.</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>N/A</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-32-3488</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b>   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 14, 1906</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |                                |   |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent   |  |   |                                |   |
|  | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTIMORE</b>  | 10c. City, Town or Location<br><b>PARKVILLE</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 10e. Street and Number<br><b>2931 NORTHWIND RD.</b>   |  | 10f. Zip Code<br><b>21234</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6<sup>th</sup></b> College (1-4or 5+) <b>NA</b> |                                |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PRINTER</b>   |  | 16b. Kind of Business/Industry<br><b>SELF EMPLOYED</b>  |                                |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH LEVIN</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |                                |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs Betty L. Moudry</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>107 LESLIE AVE. BALTO, MD. 21236</b>          |                                |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>  |                                | 20c. Location - City or Town, State<br><b>BALTO, MD.</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>HARTLEY MILLER FUNERAL HOME</b><br><b>7527 HARFORD RD. BALTO, MD. 21234</b>                                |                                |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |                                | Approximate Interval Between Onset and Death<br><br><b>8 days</b><br><br><b>8 days</b>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Colon Carcinoma, Anemia, Rectal bleed.</b>   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>   |
|  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                | 29b. Signature and title of certifier<br><b>A. Sajid MD</b>   |
| State Registrar  | 29c. License number<br><b>ID 51010</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March, 26, 1997</b>   |                                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ahmed Sajid MD - Good Samaritan Hospital</b>   |
|  | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |                                |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09420

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Reese Lewis, Jr.

2. Date of Death

Month Day Year  
March 27, 1997

3. Time of Death

4:15 am

4a. Facility Name (If not institution, give street and number)

Brightwood Center

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

234-32-1071

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 13, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2110 Folkstone Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Computer Analyst

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Thomas Reese Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Grace Emma Rodgers

19a. Informant's Name/Relationship (Type, Print)

Thomas Reese Lewis, III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2110 Folkstone Road, Timonium, MD 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Carroll Cremation Service 3/28/97 Hampstead, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia road, Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

LUNG CANCER

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shelly Cabbell

29c. License number

D38708

29d. Date signed (Month, Day, Year)

March 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Shelly Cabbell, MD 4000 Old Court Rd., suite 203, Baltimore, MD 21208

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Registrar Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1913

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09421

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Boy McCullough

2. Date of Death

Month Day Year  
MARCH 19, 1997

3. Time of Death

8:34 P.M.

4e. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

6. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

March 17, 1997

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3522 Erdman Avenue Apt. 2

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Michael

Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Regina

McCullough

19a. Informant's Name/Relationship (Type, Print)

Regina McCullough - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3522 Erdman Avenue Apt. 2, Baltimore, MD. 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

The Johns Hopkins Hospital Baltimore MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Johns Hopkins Hospital Baltimore MD

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Extreme Prematurity (24 weeks gestation)

2 days

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intraventricular hemorrhage (grade 4)

Hyaline membrane disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28e. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Estee Theodor

29c. License number

D39805

29d. Date signed (Month, Day, Year)

March 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Johns Hopkins Hospital, Neonatology, 600 N Wolfe Street, Baltimore MD 21287

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

Julia Jackson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09422

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

(Sister) Mary Ann Joseph Maddox

2. Date of Death

Month  
03Day  
25Year  
97

3. Time of Death

9:20 a.m.

4a. Facility Name (If not institution, give street and number)

Oblate Sisters of Providence (HCU)

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-26-8522

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
04-06-30

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore (Catonsville)

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

701 Gun Road

10f. Zip Code

21227-3899

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify African-American

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4 (BA)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

George Edward Maddox

18. Mother's Name (First, Middle, Maiden Surname)

Augusta Magdalen Young

19a. Informant's Name/Relationship (Type, Print)

Sister M. Alexis Fisher, OSP

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

701 Gun Road Baltimore, MD 21227-3899

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery 04-01-97 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March Funeral Home West  
4300 Wabash Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Hypoxic Brain Damage  
Due to (or as a consequence of):

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. STATUS ASTHMATICUS  
Due to (or as a consequence of):

1 week

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bronchial Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

INFIRMARY

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office,  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

021649

29d. Date signed (Month, Day, Year)

MARCH 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAM ASIKARAN, 3455 WILKENS AVE, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#6 PER. F.H. FILM#G745 2/28/97 J.A.

## Certificate of Death

Reg. No.

97 09423

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Meyls

2. Date of Death  
Month Day Year

3

27

97

1013

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Siara Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

117-03-2581

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

9/9/03

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

4669 Falls Road

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married

X Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Howard F. Wollet

18. Mother's Name (First, Middle, Maiden Surname)

Bianche M. Meyer

19a. Informant's Name/Relationship (Type, Print)

William F. Day (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

118 Allgate Road, Owings Mills, Md 21117

20a. Method of Disposition

X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cem.

Date

3/29/91

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Md 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

5 Pending investigation

2 Accident

3 Suicide

4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sheldon Goldgeier MD

29c. License number

D02397

29d. Date signed (Month, Day, Year)

3-27-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sheldon Goldgeier, 711 W 40th Street Baltimore MD

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

Sheldon Goldgeier

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,II,27,28a-f per MEO G-74664/10 Certificate of Death

Reg. No.

97 09424

|  |   |  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>STEPHEN GEORGE MILBURN SR.</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>22</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>4:15 PM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>WOODS OFF OF 349 FAIRHAVEN ROAD</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>TRACYS LANDING</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>309 10 1904</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG 21 1919</b>               |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Tracys Landing</b>                    |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>679 Fairhaven Road Box 43</b>  |  | 10f. Zip Code<br><b>20779</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                      |  | 16b. Kind of Business/Industry<br><b>Marine Construction</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Timothy Milburn</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Breeden</b>   |  |   |  |
|  | 19. Informant's Name/Relationship (Type, Print)<br><b>Erma Milburn</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>679 Fairhaven Rd, Box 43, Tracys Landing, Md. 20779</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Balto., Md</b>  |  | 20d. Date<br><b>3-25-1997</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home P.A.<br/>12 Ridgely Ave., Annapolis, Md 21401</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. DROWNING</b><br>Dua to (or as a consequence of):<br><br><b>b.</b> Dua to (or as a consequence of):<br><br><b>c.</b> Dua to (or as a consequence of):<br><br><b>d.</b> |  |   |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |   |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ALZHEIMER'S DISEASE</b>  |  |   |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>  |  |   |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |   |  |
|  | 28a. Date of Injury (Month, Day, Year)<br><b>found 3/22/97</b>  |  | 28b. Time of Injury<br><b>found 1:33 PM</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred<br><b>Wandered Off</b>                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Found: in swamp</b>  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Anne Arundel Co., Md. Off of 349 Fairhaven Rd.</b>  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                    |  |   |  | 29b. Signature and title of certifier<br>   |  |   |  |
|  | 29c. License number<br><b>O.C.M.E.</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 23, 1997</b>  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |  |   |  |
|  | State Registrar   |  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09425

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CARMEN RIVERA MONTAÑA</b>  |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>16</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>5:45 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>9900 BLOCK YORK ROAD</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TIMONIUM</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>NONE</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>3-22-52</b>                                       |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>EL SALVADOR</b>  |  | 10e. State<br><b>MD.</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>1733 E. Lombard Street</b>   |  |   |  | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>SOUTH AMERICA</b>                                       |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:    |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>SPANISH</b>                   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dishwasher</b>   |  | 16b. Kind of Business/Industry<br><b>WOOD SERVICE</b>                                       |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ALFREDO RIVERA</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HERMINIA Portillo</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>NELSON GOMEZ</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1733 E. Lombard St. Balto. Md. 21213</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SESORI CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>EL SALVADOR</b>  |  | 20d. Date<br><b>4/3/97</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Jeff Miller</b>   |  |   |  | 22. Name and Address of Facility<br><b>JEFF MILLER P.C. FUNERAL HOME + SERVICE</b><br><b>1639 N. Broadway BALTO. Md. 21213</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Acute Proprietary Intoxication</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Field</b> |  |  |  |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Feb 2-16-97</b>  |  | 28b. Time of injury<br><b>UNK</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Border Line</b>  |  |   |  | 28d. Describe how injury occurred<br><b>Unknown</b>  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>9900 Bk. York Rd. Timonium MD</b>  |  |   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>Chambers</b>  |  |   |  | 29b. Signature and title of certifier<br><b>Chambers</b>   |  |   |  |
|   | 29c. License number<br><b>O.C.M.E.</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 17, 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JTA RON LEE, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>Registrar</b>   |  |   |  | 33. Registrar's Title<br><b>Registrar</b>  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09426

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CARL DEYERLE MORRIS</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>2:10 PM.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6422 KENWOOD AVE.</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>ROSEDALE</b>   |  | 4c. County of Death<br><b>Baltimore County</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>226-10-7161</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>79</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 18, 1917</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore County</b>  |  | 10c. City, Town or Location<br><b>Rosedale</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6422 Kenwood Avenue</b>  |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Welder</b>  |  | 16b. Kind of Business/Industry<br><b>Welding Company</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Butler Morris</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosa Mae Landis</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carole M. Kassel/Niece</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>310 E. Belcrest Road, Bel Air, Maryland 21014</b>   |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   |  | 20c. Date<br><b>3/27/97</b>   |  | 20d. Location - City or Town, State<br><b>Beltsville, Maryland</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Quantia R Thomas</b>  |  | 22. Name and Address of Facility<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>   |  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>b. Due to (or as a consequence of):</b>   |  | 23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>c. Due to (or as a consequence of):</b> |  | 23d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>d. Due to (or as a consequence of):</b>   |  |   |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Dennis J. Chute MD</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 26, 1997</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute MD</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  | 32. Registrar's Signature<br><b>J. Davidson</b>   |  | 33. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09427

|  |   |  |  |   |  |                                |  |  |
|--|---|--|--|---|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Marie Catherine Oldewurtel  |  |  |   | 2. Date of Death<br>Month Day Year<br>March 21, 1997   |                                | 3. Time of Death<br>7:11 p.m.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Health Services  |  |  |   | 4b. City, Town, or Location of Death<br>Rosedale   |                                | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-05-6255  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>89 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>December 9, 1907  | 9. Birthplace (State or Foreign Country)<br>Maryland |
|  | Usual Residence of Decedent   |  |  |   | 10a. State<br>Maryland   |                                | 10b. County<br>N/A   |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br>Baltimore  |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                | 10e. Street and Number<br>5730 Newholme Road   |  |
|  | 10f. Zip Code<br>21206  |  |  |   | 10g. Citizen of What Country?<br>U.S.A.  |                                | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4or 5+)<br>8 th. Grade  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Seamstress  |                                | 16b. Kind of Business/Industry<br>Tailoring Shop   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Henry Unknown Oldewurtel   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sadie Unknown Bauerfiend  |                                |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Charles B. Kropfelder/Nephew  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>112 Sipple Avenue Baltimore, MD 21236   |                                |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Redeemer Cemetery 3/24/97   |                                | 20c. Location - City or Town, State<br>Baltimore, MD   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |   | 22. Name and Address of Facility<br>John C. Miller, Inc.<br>6415 Belair Road Baltimore, MD 21206   |                                |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Atherosclerotic heart<br>b. pneumonia<br>c.<br>d. |  |  |   | Approximate Interval Between Onset and Death<br>7-10 years<br>2 WK   |                                |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M       |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  | 28d. Describe how injury occurred   |  |                                |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br>   |  |                                |  |  |
| 29c. License number<br>D43627  |   |  |  | 29d. Date signed (Month, Day, Year)<br>3-23-97  |  |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>7600 Oyster Pointe   |   |  |  | 31. Date filed (Month, Day, Year)<br>MAR 28 1997  |  |                                |  |  |

Baltimore, Maryland 21215-0020

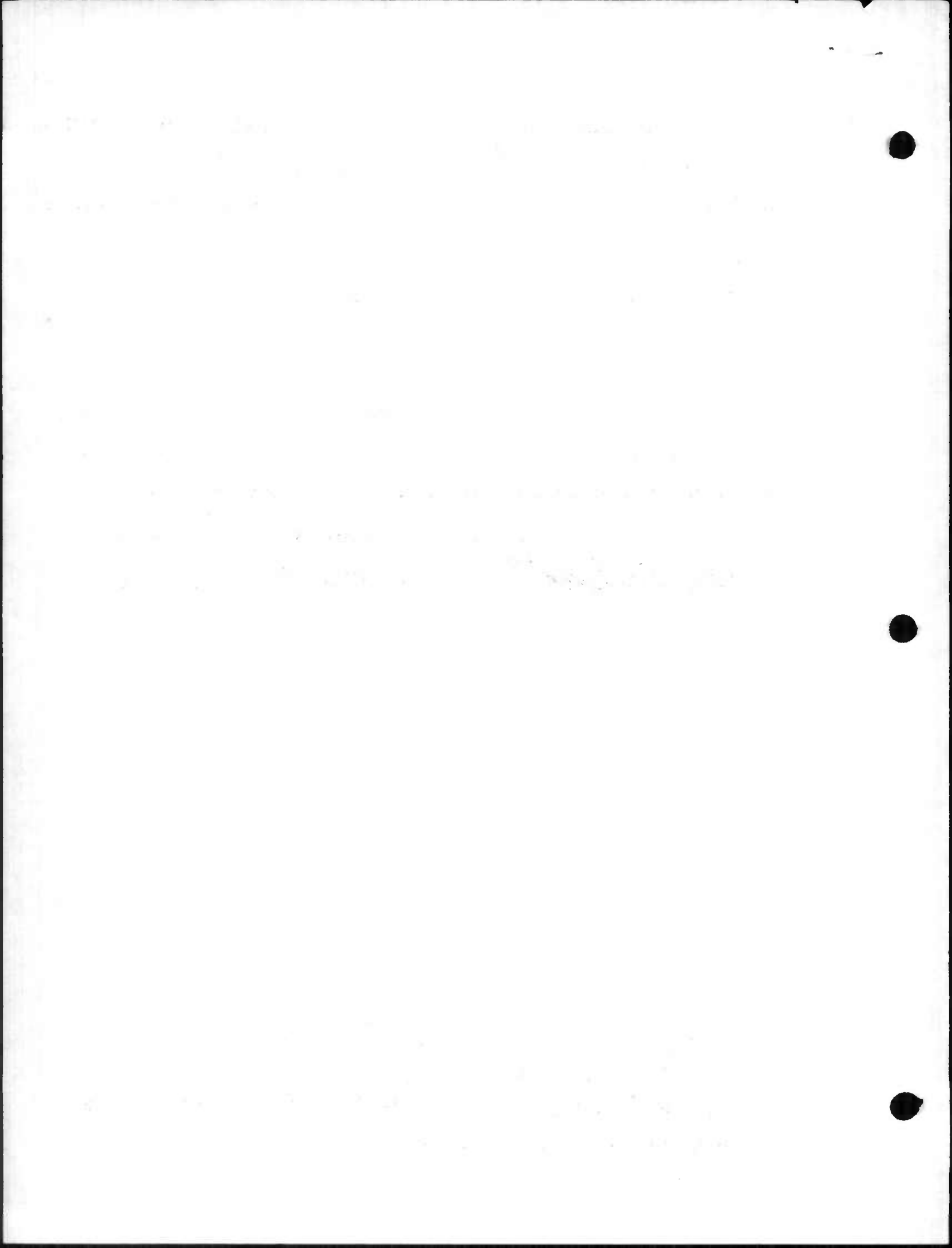
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09428

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMIL O PETERSON JR

2. Date of Death

March 27 1997

3. Time of Death

1255 AM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

565 05 2081

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 17 1909

9. Birthplace (State or Foreign Country)

CA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4017 LIBERTY HEIGHTS AVE

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MINISTER

16b. Kind of Business/Industry

ASSEMBLY OF GOD

17. Father's Name (First, Middle, Last)

EMIL O. PETERSON SR

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

SHARON FREMD

NEICE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 SHARON DR PASADENA MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

3.28.97

20c. Location - City or Town, State

BALTO MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Raymond C. Fink Funeral Home  
426 Cedar Hwy SW GLEN BURR MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive Heart Failure

Due to (or as a consequence of):

b.

Arteriosclerotic Vascular disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-08225

29d. Date signed (Month, Day, Year)

March 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NORRIS L. HORWITZ, M.D.

5401 OLD COURT ROAD, RANDALLSTOWN MD 21133

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |   |  |
|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN PAHL</b>   |  |  | 2. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>27</b> YEAR <b>1997</b>  |   | 3. TIME OF DEATH<br><b>9:30 PM</b>                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-07-6438</b>  | 5. SEX<br><b>XX</b> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.   | 7. DATE OF BIRTH<br>MONTH <b>May</b> DAY <b>27</b> YEAR <b>1910</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manor Care - Ruxton</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |   | 9c. COUNTY OF DEATH<br><b>Baltimore Co</b>  |   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |   |  |
| 10a. STATE<br><b>Maryland</b>  | 10b. COUNTY<br><b>Baltimore</b>                  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |   |  |
| 10e. STREET AND NUMBER<br><b>7001 N. Charles Street</b>  |  | 10f. ZIP CODE<br><b>21204</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |   |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>7th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plant Worker</b>   |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Paul Jones Distillery</b>  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick Pahl</b>   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary E. Brooks</b>  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John E. Pahl, Jr. (Son)</b>   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Dawson Dr, Cockeysville, Md 21033</b> |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem Gdn 3/29/97</b>   |   | 20c. LOCATION (City or Town, State, Zip Code)<br><b>Cockeysville, Md 21030</b>  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>A. Alan Seitz, Jr. Funeral Home<br/>3818 Roland Avenue, Balto, Md 21211</b>                            |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF KIDNEY</b>   |  |  |   |   |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |   |   |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |   |   |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |   |   |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |   |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  | 28b. TIME OF INJURY<br>M  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  | 28d. DESCRIBE HOW INJURY OCCURRED                     |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  | 29c. LICENSE NUMBER<br><b>D-12849</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>3-27-97</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A.H. GHILADI, MD 7600 OSLER Dr. TOWSON, MD.</b>  |  |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAR 28 1997</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

34VA





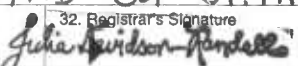
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09430

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |   |  |  |
|---|--|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Provenzano</b>                       |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b> |   | 3. Time of Death<br><b>11:15 PM</b>                        |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>5040 Federal Street</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |   | 4c. County of Death<br><b>N/A</b>                          |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-30-5092</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>June 2, 1935</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>5040 Federal Street</b>  |  | 10f. Zip Code<br><b>21205</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>  |  | 16b. Kind of Business/Industry<br><b>Regional Management</b>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Patrick Kelly</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Loretta Gipprich</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeff Provenzano (Son)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1212 63rd Street, Baltimore, Maryland 21237</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  | 20c. Date<br><b>3-31</b>  |   | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home</b><br><b>3331 Brehms Lane, Baltimore, Maryland 21213</b>   |  | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Non Small Cell Carcinoma of Lung</b>         |   | Approximate Interval Between Onset and Death<br><b>1 1/4 year</b>   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)  |  |  |
| 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D40854</b>  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>3/28/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DAVID RISEBERG, M.D. 301 ST. PAUL PL. #407 T BALTO, MD. 21202</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |   | 32. Registrar's Signature<br>                                    |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09431

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES WILLIAM POLLEY SR.

2. Date of Death

MARCH 21 1997

3. Time of Death

11:00 PM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MD.

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

214-12-8874

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 24, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7422 Brookwood Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates

8/19/44 - 9/18/53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sheet Metal Mechanic

16b. Kind of Business/Industry

Electronics Company

17. Father's Name (First, Middle, Last)

Thomas Easter Polley

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Francis Schultz

19a. Informant's Name/Relationship (Type, Print)

Katherine Elaine Polley / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7422 Brookwood Avenue, Baltimore, Maryland 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery

Date

3/25/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller, Inc.  
6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA ALZHEIMER'S

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41410

29d. Date signed (Month, Day, Year)

March 22, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOGINDER P. MEHTA M.D. ST. JOSEPH MEDICAL CENTER TOWSON, MD.

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09432

|   |   |   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|---|---|---|---|---|--|--|---|--|---|---------------------------------|--|-----------------------------|-----------------|----------|--|----------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Edward, S., Quince</u>   |   |   |   | 2. Date of Death<br>Month <u>March</u> Day <u>26</u> Year <u>1997</u>  |  | 3. Time of Death<br><u>17:20</u>  |  |   |                                 |  |                             |                 |          |  |          |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>ST. AGNES HOSPITAL</u>   |   |   |   | 4b. City, Town, or Location of Death<br><u>BALTIMORE CITY</u>  |  | 4c. County of Death<br><u>N/A</u>                                       |  |   |                                 |  |                             |                 |          |  |          |
| Funeral<br>Director   | 5. Social Security Number<br><u>212-18-5244</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>77</u> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>Sept. 26, 1919</u>            |  |   |                                 |  |                             |                 |          |  |          |
|   | 9. Birthplace (State or Foreign Country)<br><u>Balto. Md.</u>   |   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
| To Be Completed by Funeral Director   | 10e. State<br><u>MD.</u>  |   | 10b. County<br><u>N/A</u>   |   | 10c. City, Town or Location<br><u>Baltimore City</u>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |                                 |  |                             |                 |          |  |          |
|   | 10e. Street and Number<br><u>3600 West Franklin St. Apt. 8P</u>   |   |   |   | 10f. Zip Code<br><u>21229</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>                          |  |   |                                 |  |                             |                 |          |  |          |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u> |  |   |                                 |  |                             |                 |          |  |          |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6th</u> College (1-4 or 5+)   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Laborer</u> |  |  | 16b. Kind of Business/Industry<br><u>Balto. City Public Works</u>       |  |   |                                 |  |                             |                 |          |  |          |
|   | 17. Father's Name (First, Middle, Last)<br><u>Walter Quince</u>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Mary Quince</u>  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><u>Kathy Quince (Daughter)</u>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>6 Aspinwood Way Apt. B Balto. Maryland 21237</u>   |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Arbutus Memorial Park</u>  |   | 20c. Location - City or Town, State<br><u>4-1 Baltimore, Maryland</u>  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | 21. Signature of Funeral Service Licensee<br><u>William C. Brown</u>  |   |   |   | 22. Name and Address of Facility<br><u>Funeral Home P.A. 1206 W. North Ave.</u>  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <u>Chronic Renal Failure</u></td> <td>Approximate Interval Between Onset and Death<br/><u>3 Years</u></td> </tr> <tr> <td>b. <u>Diabetes mellitus</u></td> <td><u>20 years</u></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> |   |   |   |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <u>Chronic Renal Failure</u> | Approximate Interval Between Onset and Death<br><u>3 Years</u> | b. <u>Diabetes mellitus</u> | <u>20 years</u> | c. _____ |  | d. _____ |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. <u>Chronic Renal Failure</u>   | Approximate Interval Between Onset and Death<br><u>3 Years</u>  |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | b. <u>Diabetes mellitus</u>   | <u>20 years</u>   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | c. _____  |   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
|   | d. _____  |   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>congestive heart failure</u>   |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |                                 |  |                             |                 |          |  |          |
|   |   |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                 |  |                             |                 |          |  |          |
|   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                 |  |                             |                 |          |  |          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28e. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                 |  |                             |                 |          |  |          |
|   |   | 28d. Describe how Injury occurred   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |                                 |  |                             |                 |          |  |          |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
| 29b. Signature and title of certifier<br><u>William C. Brown</u>  |   | 29c. License number<br><u>PO 9140</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>March 26-1997</u>   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>MUNIF RAHAL, ST. Agnes Hospital, 900 Caton Ave, Balt. MD 21229</u>   |   |   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |
| 31. Date filed (Month, Day, Year)<br><u>MAR 28 1997</u>   |   | 32. Registrar's Signature<br><u>John Davidson-Randall</u>   |   |   |  |  |   |  |   |                                 |  |                             |                 |          |  |          |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09433

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>SAROJANIE RAMANOO</i>  |  | 2. Date of Death<br>Month <i>MARCH</i> Day <i>26</i> Year <i>1997</i>  |  | 3. Time of Death<br><i>4:05 PM</i>   |
|   | 4e. Facility Name (If not institution, give street and number)<br><i>THE JOHNS HOPKINS HOSPITAL</i>   |  | 4b. City, Town, or Location of Death<br><i>BALTIMORE CITY</i>  |  | 4c. County of Death<br><i>N/A</i>  |
| Funeral<br>Director   | 5. Social Security Number<br><i>N/A</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><i>65</i> Yrs.   | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><i>Aug. 30, 1931</i>   |  | 9. Birthplace (State or Foreign Country)<br><i>West Indies</i>   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10e. State<br><i>England</i>   |  | 10b. County<br><i>N/A</i>  |
|   | 10c. City, Town or Location<br><i>London</i>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|   | 10e. Street and Number<br><i>1 Cartwright St. Royal Mint Square</i>   |  | 10f. Zip Code<br><i>E 18LY</i>   |  | 10g. Citizen of What Country?<br><i>United Kingdom</i>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br><i>West Indian</i>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>16 Years</i> College (1-4 or 5+) <i>Seamstress</i>   |  |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Seamstress</i>   |  | 17. Kind of Business/Industry<br><i>Clothing</i>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>Philip Doodnath</i>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Esther Samaroo</i>   |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><i>Ina Ramkalawan/Daughter</i>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7810 St. Gregory Drive Dundalk, Maryland 21222</i> |  |  |
|   | 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>East London Crematorium</i>   |  | 20c. Location - City or Town, State<br><i>London, England</i>  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><i>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</i>                          |  |  |
| Physician<br>/Medical<br>Examiner   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |  |  | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><i>MYOCARDIAL ISCHEMIA</i>   |  |  |  | <i>4 months</i>  |
|   | Due to (or as a consequence of):<br><i>CORONARY Artery Disease</i>  |  |  |  | <i>20 years</i>  |
|   | Due to (or as a consequence of):<br><i>HT PERTENSION</i>  |  |  |  | <i>30 years</i>  |
|   | Due to (or as a consequence of):  |  |  |  |  |
|   | Due to (or as a consequence of):  |  |  |  |  |
|   | Due to (or as a consequence of):  |  |  |  |  |
|   | Due to (or as a consequence of):  |  |  |  |  |
|   | Due to (or as a consequence of):  |  |  |  |  |
|   | Due to (or as a consequence of):  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28e. Date of Injury (Month, Day, Year)                                       |  | 28b. Time of Injury<br><i>M</i>                              |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature] MD</i>  |   | 29c. License number<br><i>RES-000</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>March 26, 1997</i> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>RICHARD REDETT 600 North Wolf Street, Baltimore, Maryland 21287</i>  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>MAR 28 1997</i>   |   |  |  |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 09434

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dolly M. Robison

2. Date of Death

Month

Day

Year

MARCH

22

1997

3. Time of Death

12:00 P

4a. Facility Name (If not institution, give street and number)

8205 BODKIN AVE

4b. City, Town, or Location of Death

PASADENA

4c. County of Death

AA Co.

Funeral  
Director

5. Social Security Number

219146326

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

FEB 5 1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

AA Co.

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8205 BODKIN AVE

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ROBERT SHANHOLTZ

18. Mother's Name (First, Middle, Maiden Surname)

VIRGIE O. YOUNGBLOOD

19a. Informant's Name/Relationship (Type, Print)

BONNIE MILLER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8205 BODKIN AVE PASADENA MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CROWNSVILLE VET CEM

Date

3.24.97

20c. Location - City or Town, State

CROWNSVILLE MD

21. Signature of Funeral Service Licensee

Thomas J. Shandak

22. Name and Address of Facility

Raymond C. Fink Funeral Home

426 CRAIN HWY SW GLEN BURNIE MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Markkan

29c. License number

D39505

29d. Date signed (Month, Day, Year)

March 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yudhish Markkan 1406-B Crain Hwy, Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

Richard R. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09435

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
|---|---|---|--|--|---|--|---|--|---|---|-----------------------------------|--|--|----|----|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Frederick Andrew Spiri</b>   |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>7:40 AM</b>                                      |  |   |   |                                   |  |  |    |    |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7507 Haines Court</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>   |  | 4c. County of Death<br><b>Prince George</b>                             |  |   |   |                                   |  |  |    |    |    |
| Funeral<br>Director   | 5. Social Security Number<br><b>206-18-1024</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 25, 1925</b>              |  |   |   |                                   |  |  |    |    |    |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Laurel</b>                            |  |   |   |                                   |  |  |    |    |    |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>7507 Haines Court</b>   |  | 10f. Zip Code<br><b>20707</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |   |                                   |  |  |    |    |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-46</b><br><b>1948-54</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |   |                                   |  |  |    |    |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>2</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Logistics Specialist</b>   |  | 16b. Kind of Business/Industry<br><b>Dept. of Defense</b>   |  |   |  |   |   |                                   |  |  |    |    |    |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Spiri</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Chenot</b>   |  |   |  |   |   |                                   |  |  |    |    |    |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Spiri/Wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7507 Haines Court, Laurel, Maryland 20707</b>   |  |   |  |   |   |                                   |  |  |    |    |    |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr.</b>  |  | Date<br><b>3/27</b>   |  | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>          |  |   |   |                                   |  |  |    |    |    |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.</b><br><b>7601 Sandy Spring Road, Laurel, Maryland 20707</b>   |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">           {         </td> <td>a. <b>CORONARY ARTERY DISEASE</b></td> <td rowspan="4">           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>YEARS</b> </td> </tr> <tr><td>b.</td></tr> <tr><td>c.</td></tr> <tr><td>d.</td></tr> </table> |   |  |  |   |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { | a. <b>CORONARY ARTERY DISEASE</b> | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><b>YEARS</b> | b. | c. | d. |
|   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | {   | a. <b>CORONARY ARTERY DISEASE</b>  | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><b>YEARS</b>  |  |   |  |   |   |                                   |  |  |    |    |    |
| b.  |   |   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
| c.  |   |   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
| d.  |   |   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEVERE PARKINSONS DISEASE</b><br><b>CONGESTIVE HEART FAILURE</b>   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |   |   |                                   |  |  |    |    |    |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |   |                                   |  |  |    |    |    |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |   |   |                                   |  |  |    |    |    |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
| 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br><b>D24997</b>   |   | 29d. Date signed (Month/Day, Year)<br><b>3/26/97</b>   |   |  |   |   |                                   |  |  |    |    |    |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>LUIS A. CASAS MD 8317 CHERRY LANE LAUREL MD. 20707</b>   |   |   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |   | 32. Registrar's Signature<br>   |  |  |   |  |   |  |   |   |                                   |  |  |    |    |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09436

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED WELLS STOWE

2. Date of Death

March 23 1997

3. Time of Death

0850

4a. Facility Name (If not institution, give street and number)

UNION HOSPITAL

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

577-07-2402

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 31, 1912

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

CECIL

10c. City, Town or Location

ELKTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

100 LAUREL DRIVE

10f. Zip Code

21921

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALESMAN

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

FREDERICK E. STOWE

18. Mother's Name (First, Middle, Maiden Surname)

AMY FLORENCE SUTTON

19a. Informant's Name/Relationship (Type, Print)

SUSAN PADRINO

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

609 MAUSER DRIVE, BEL AIR, MARYLAND 21015

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JONES CREMATION SERVICE 3-25-97 WINCHESTER, VIRGINIA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin W. Turner

22. Name and Address of Facility

TURNER-ROBERTSHAW FUNERAL HOME  
1200 N. SHENANDOAH AVE., FRONT ROYAL, VA. 22630

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

1 DAY

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PARKINSON'S DISEASE

7 YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Andrew Nowakowski MD

29c. License number

D09086

29d. Date signed (Month, Day, Year)

MARCH 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BELAIR, MD 21014

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09437

|  |   |   |  |   |  |  |  |  |
|--|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LENORE SHORTRIDGE</b>                          |   |  |   | 2. Date of Death<br>Month <b>Day</b> Year<br><b>MARCH 25, 1997</b> |  | 3. Time of Death<br><b>2355 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1203 ANGLESEA STREET</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>           |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-26-1314</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | If Under 1 Year<br>Months Days                                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JUL 18, 1930</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Penna.</b>  |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1203 Anglesea Street</b>  |   |   |  | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) unk</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Barth</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Cammer</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stephen Shortridge (Son)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>822 Leswood Court, Dundalk, Md 21222</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>   |  | Date<br><b>3/29/97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Md</b>  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>A. Alan Seitz, Jr.; Funeral Home<br/>3818 Roland Ave.; Balto, Md 21211</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 26, 1997</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |   |   |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 09438**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David Stallings

2. Date of Death

March 21, 1997

3. Time of Death

0233

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

244-34-5126

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR. 7, 1928

9. Birthplace (State or Foreign Country)

CONCORD, N.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

A.A. CO

10c. City, Town or Location

RIVERDALE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4806 SHERIDAN ST.

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STAFF SERGEANT

16b. Kind of Business/Industry

UNITED STATES ARMY

17. Father's Name (First, Middle, Last)

WILLIAM S. STALLINGS

18. Mother's Name (First, Middle, Maiden Surname)

ALICE HARVELL

19a. Informant's Name/Relationship (Type, Print)

FAYE STALLINGS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4806 SHERIDAN ST. RIVERDALE MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CABARRUS MEM. GARDENS

Date

MAR. 25 1997

20c. Location - City or Town, State

CONCORD, N.C.

21. Signature of Funeral Service Licensee

Thomas J. Standa Jr.

22. Name and Address of Facility

SKARDA FH. 2829 HUDSON ST. BALTIMORE MD. 21224

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Distress Synd (ARDS)

Due to (or as a consequence of):

b. Suspected Pulmonary Infection

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPOXEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Darryl Hill

29c. License number

P09737

29d. Date signed (Month, Day, Year)

3/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darryl Hill, M.D., 10 North Greene Street, Balto., MD 21201

31. Date filed (Month, Day, Year)

MAR 28 1997

Registrar's Signature

John L. Hill

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09439

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN J. SCHLAFFER</b>   |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>3:00 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>806 S. STREEPER ST.</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-03-1353</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 24, 1915</b>  |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                      |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>806 S. STREEPER ST.</b>   |  |
|   | 10f. Zip Code<br><b>21224</b>  |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ELEC</b>  |  | 16b. Kind of Business/Industry<br><b>BETH-STEEL CO.</b>  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>CHARLES SCHLAFFER</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET DUCHESNY</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>WILLIAM SCHLAFFER</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9300 OAK WHITE RD. BALTO. MD. 21236</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HOLY REDEEMER CH. MAR 29 1997</b>  |  | 20c. Location - City or Town, State<br><b>BALTO. MD.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Thomas J. Skarda Jr.</b>   |  |  |  | 22. Name and Address of Facility<br><b>SKARDA FH. 2829 HUDSON ST. BALTIMORE, MD. 21224</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>likely Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>? Aortic Aneurysm</b><br><b>Hypertension</b><br><b>COAD</b>   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  |
|   | 28a. Date of Injury (Month, Day, Year)   |  |  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Melvin Melinsky</b>  |  |  |  | 29c. License number<br><b>D-27921</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/27/97</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mel. Melinsky MD - 3411 Bank St. Balt. 21224</b>  |  |  |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |  |  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE F. SCHAECHTEL</b>  |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>15</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>12:50 P.M.</b>                                   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4036 SIXTH STREET</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>CITY</b>                                      |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-44-3464</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   | If Under 1 Year<br>Months Days         | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 19, 1944</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>             |
|  | Usual Residence of Decedent  |  |  |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>  | 10b. County<br><b>CITY</b>   | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>4036 SIXTH STREET</b>   |  | 10f. Zip Code<br><b>21225</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1961-64</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ARTIST</b>                                       |  | 16b. Kind of Business/Industry<br><b>PAINT</b>   |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>ADAM SCHAECHTEL</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY PEARCE</b>  |  |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>EDWARD SCHAECHTEL/BROTHER</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1902 ALICEANNA BALTIMORE, MARYLAND 21231</b>   |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CEMETERY</b>  |  | Date<br><b>MARCH 22</b>  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                              |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Elizabeth A. Selinski</i>  |  |  |  | 22. Name and Address of Facility<br><b>LILLY &amp; ZEILER, INC. FUNERAL HOME</b><br><b>1901 EASTERN AVENUE BALTIMORE, MARYLAND 21231</b>   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. CONTACT GUNSHOT WOUND OF HEAD</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |  |  |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |  |  |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND 3/15/97</b>   |  | 28b. Time of Injury<br><b>1250 M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred<br><b>SUBJECT SHOT SELF</b>                                  |   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>BASEMENT</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4036 6th STREET BALTIMORE, MARYLAND</b> |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Theodore King M.D.</i>   |  |  |  | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 16, 1997</b>                                   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |  |  |  |  |  |  |   |
| 32. Registrar's Signature<br><i>Theodore King M.D.</i>   |  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09441

ITEM: 17 per FH G-745 3-28-97 eoh

## Certificate of Death

Reg. No.

|   |   |  |   |                                |  |
|---|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>LEWIS SIPERKO</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>4:55 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>204 05 4610</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 19, 1920</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |                                |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent   |  | 10a. State<br><b>MARYLAND</b>   |                                | 10b. County<br><b>BALTIMORE</b>  |
|   | 10c. City, Town or Location<br><b>CATONSVILLE</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |  |
|   | 10e. Street and Number<br><b>Frederick House at<br/>709 Maiden Choice Lane</b>  |  | 10f. Zip Code<br><b>21228</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1/2/1942</b><br>If Yes, Give Year or Dates: <b>10/3/1945</b>  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|   | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>1</b>  |                                |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>   |  | 16b. Kind of Business/Industry<br><b>Black &amp; Decker</b>   |                                |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Louis Sipenko</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margarete Gwynne</b>  |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Steven J. Siperko</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8604 Northfields Circle, Lutherville, MD 21093</b>  |                                |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation Services</b>   |                                | 20c. Location - City or Town, State<br><b>Hampstead, MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Bryan W. Clary</b>  |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home of Dulaney Valley, Inc.<br/>10 W. Padonia Rd., Timonium, MD 21093</b>  |                                |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.<br>shock, or heart failure. List only one cause on each line.  |  |   |                                | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. pleural effusions + abscess</b><br>Due to (or as a consequence of):  |  |   |                                | <b>? 2 weeks</b>   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. pneumonia</b><br>Due to (or as a consequence of):   |  |   |                                | <b>approx 2 wks.</b>   |
|   | Due to (or as a consequence of):<br><b>c.</b>   |  |   |                                |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>dementia</b>   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |                                |  |
|   | 29b. Signature and Title of Certifier<br><b>Medical Howes</b>   |  | 29c. License number<br><b>JHMC 96705</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>MARCH 25, 1997</b>   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kenneth J. Cotter, M.D., JHMC, 4940 Eastern Avenue, Baltimore, MD 21224</b>  |  |   |                                |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  | 32. Registrar's Signature<br><b>Adrian</b>  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09442

|  |   |  |  |  |   |  |   |  |
|--|---|--|--|--|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>KAREN SILLAH</b>   |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>24</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>10:30 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>34 DALAMAR ST.</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>GAITHERSBURG</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>189-50-7221</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>09/29/1963</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>  |  | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Gaithersburg</b>  |  |
| <b>To Be Completed by Funeral Director</b>   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>34 Delmar St. Apt. #5</b>  |  | 10f. Zip Code<br><b>20877</b>   |  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>College</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietician</b>   |  | 16b. Kind of Business/Industry<br><b>Nursing Home</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Barry James Moore, Sr.</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mabel Johnson</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen Moore/Daughter</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>498 Denhigh Blvd. #166 Newport News, VA. 23608</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenlawn Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>3/28/97 Chester Township, PA.</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Sterling Ashton Funeral Home, Inc.<br/>736 Edmondson Ave. Baltimore, MD. 21228</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Shotgun wound to Abdomen</b><br>Dua to (or as a consequence of):<br><br><b>b.</b> Dua to (or as a consequence of):<br><br><b>c.</b> Dua to (or as a consequence of):<br><br><b>d.</b> |  |  |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |  |   |  |   |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)<br><b>3-22-97</b>  |  | 28b. Time of Injury<br><b>Unknown AM</b>  |  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred<br><b>Subject shot</b>  |  |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b>  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>34 Dalamar St</b>  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| <b>State Registrar</b>   | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 25, 1997</b>  |  |
|  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>  |   |  |  | 32. Registrar's Signature<br> |   |  |   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09443

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond George Sauerwald

2. Date of Death

March 25 1997

Day

Year

3. Time of Death

01.20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-10-4884

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 24, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford County

10c. City, Town or Location

Abingdon

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3236 Split Oak Court

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give Year or Dates:

4/15/43-

10/27/45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th Grade

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chauffeur

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Charles Edwin Sauerwald

18. Mother's Name (First, Middle, Maiden Surname)

Marion Alice Lackey

19a. Informant's Name/Relationship (Type, Print)

Dorothy Ann Beeker/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3236 Split Oak Court, Abingdon, Maryland 21009

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

3/28/97

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility

John C. Miller, Inc.

6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure.

Due to (or as a consequence of):

unknown.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Cardiomyopathy.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral Deep vein thrombosis; Colon Cancer

Stroke.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

☐ Yes ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. El-Harbi MD

29c. License number

A1243 8946.

29d. Date signed (Month, Day, Year)

3/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. El-Harbi, MD 201 E. Univ. Pkwy., Baltimore, MD 21218

31. Date filed (Month, Day, Year)

MAR 28 1997

Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
the funeral director, page 2 should be detached for use as the burial-transit  
certificate.



97 09444

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Michael Van Sant</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 26, 1997</i>   |  | 3. TIME OF DEATH<br>HOURS MIN.<br><i>7:30P</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>160-46-6867</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>43</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>March 21 1954</i>                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>3 Hazy Dawn Ct., Apt. D</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Cockeysville</i>  |  | 9c. COUNTY OF DEATH<br><i>Baltimore</i>   |   |
| 10a. STATE<br><i>MD</i>  |  |   |  | 10b. COUNTY<br><i>Baltimore</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Cockeysville</i>  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><i>3 Hazy Dawn Ct., Apt. D</i>   |  |   |  | 10f. ZIP CODE<br><i>21030</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 5+) <i>n/a</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Supervisor</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Manufacturing</i>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>William Earl Van Sant</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Sara Gertrude Catherman</i>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Lisa Marie Van Sant</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1611 Steeplechase Dr., Jarrettsville, MD 21084</i>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>St. John the Evangelist Cem. 3/31/97</i>  |  | 20c. LOCATION — City or Town, State<br><i>Hydes, MD</i>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lowell M. Lemmon</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Lemmon Funeral Home<br/>10 W. Padonia Rd., Timonium, MD 21093</i>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>a. Cardiac Arrhythmia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>b. Arteriosclerotic Cordis Vasculum Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>HOURS MIN.<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles F. O'Donnell MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D-09383</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>3-27-97</i>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Charles F. O'Donnell MD - 111 Hamlet Hill Rd Baltimore MD 21210</i>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>3-28-1997</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Davidson-Rose</i>   |  |   |   |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09445

## Certificate of Death

Reg. No.

|   |   |   |  |                                     |  |   |   |   |  |   |  |  |
|---|---|---|--|-------------------------------------|--|---|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Richard J. Weston</u>  |   |  |                                     | 2. Date of Death<br>Month <u>MARCH</u> Day <u>26</u> Year <u>1997</u>  |   |   | 3. Time of Death<br><u>12:50 am</u>                                     |  |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Keswick Nursing Home</u>   |   |  |                                     | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |   |   | 4c. County of Death<br><u>N/A</u>                                       |  |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>087-22-9711</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                                     | 7. Age (In yrs. last birthday)<br><u>67</u> Yrs.   |   | 8. Date of Birth<br>Month <u>AUG</u> Day <u>24</u> Year <u>1929</u> |   | 9. Birthplace (State or Foreign Country)<br><u>New York</u>                                    |   |  |  |
|   | Usual Residence of Decedent   |   |  |                                     |  |   |   |   |  |   |  |  |
| To Be Completed by Funeral Director   | 10e. State<br><u>MD</u>   |   | 10b. County<br><u>Carroll</u>  |                                     | 10c. City, Town or Location<br><u>Westminster</u>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
|   | 10e. Street and Number<br><u>533 Baltimore Blvd.</u>  |   |  |                                     | 10f. Zip Code<br><u>21157</u>  |   |   | 10g. Citizen of What Country?<br><u>USA</u>                             |  |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>1946-48</u> |                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (14 or 5+) <u></u>   |   |  |                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Motel Clerk</u>  |   |   | 16b. Kind of Business/Industry<br><u>Motel Industry</u>                 |  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>John Francis Weston</u>   |   |  |                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Marie Scholl</u>   |   |   |   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br><u>June Marie Evans/daughter</u>  |   |  |                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>12 Mamopa Ct. Reisterstown, MD 21136</u>   |   |   |   |  |   |  |  |
|   | 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   |  |                                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metro Crematory, Inc.</u>   |   |   | 20c. Location - City or Town, State<br><u>Baltimore, MD</u>             |  | 20a. Date<br><u>3/27/97</u>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Dawn F. McDonald</u>  |   |  |                                     | 22. Name and Address of Facility<br><u>Cremation Society of Maryland, Inc.</u><br><u>299 Frederick Rd. Baltimore, MD 21228</u>   |   |   |   |  |   |  |  |
|   | 23e. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                               |   |  |                                     |  |   |   |   |  |   | Approximate Interval Between Onset and Death |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><u>B-CELL LYMPHOMA STAGE IV</u>  |   |  |                                     |  |   |   |   |  |   | <u>7 mos</u>                                 |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |  |                                     |  |   |   |   |  |   |  |  |
| Due to (or as a consequence of):<br><u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>  |   |   |  |                                     |  |   |   |   |  | <u>UNKNOWN</u>  |  |  |
| Due to (or as a consequence of):<br><u>ISCHEMIC CARDIOMYOPATHY</u>  |   |   |  |                                     |  |   |   |   |  | <u>4 yrs</u>  |  |  |
| Due to (or as a consequence of):<br><u>PERIPHERAL VASCULAR DISEASE</u>  |   |   |  |                                     |  |   |   |   |  | <u>7 yrs</u>  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>SYSTEMIC CHEMOTHERAPY (CHOP REGIMEN)</u><br><u>RECENT SEPTIC SHOCK SYNDROME</u>  |   |   |  |                                     |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |                                     |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |                                     |  |   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)                             |  | 28b. Time of Injury<br><u>M</u>     |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                       |  |   |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><u>Chloe Anderson MD</u> |  | 29c. License number<br><u>12399</u> |  | 29d. Date signed (Month, Day, Year)<br><u>MARCH 27, 1997</u>                                |   |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>Charles Anderson MD Keswick 700 W. 46th St Baltimore, MD 21211</u>   |   |   |  |                                     |  |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>MAR 28 1997</u>   |   |   |  |                                     |  |   |   |   |  | 32. Registrar's Signature<br><u>Davidson-Randell</u>  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To be completed by the attending physician: The law requires that the death certificate be executed within 72 hours after death.

To be completed by the funeral director: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM# 12 PER F.H. FLM#G746 4-1-97 J.A.

Certificate of Death

Reg. No.

97 09446

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carole Lee Wisor

2. Date of Death

Month Day Year  
March 24, 1997

3. Time of Death

1:00am

4a. Facility Name (If not institution, give street and number)

Genesis Health Care

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

006-50-6291

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 9, 1948

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1689 Baltimore &amp; Annapolis Blvd.

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hair Stylist

16b. Kind of Business/Industry

Cosmetology

17. Father's Name (First, Middle, Last)

Herbert C. Lowell

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Lovejoy

19a. Informant's Name/Relationship (Type, Print)

James H. Lowell - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1689 Baltimore &amp; Annapolis Blvd. Arnold, MD

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

3-25-1997

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Batal J. ...

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Batal J. ...

29c. License number

D21776

29d. Date signed (Month, Day, Year)

MARCH 25 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURYA MUNDRA MD 8109 RITCHIE HIGHWAY PASADENA MD

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

Wilson-Randall

21122

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09447

|   |  |  |   |  |  |  |
|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lula M. Wheeley</b>   |  | 2. Date of Death<br>Month Day Year<br><b>March 27, 1997</b>   |  | 3. Time of Death<br><b>7:35 A.M.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care Ruxton</b>   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore Co.</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-50-7021</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 29, 1908</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore Co.</b>  |  |
|   | 10c. City, Town or Location<br><b>Towson</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|   | 10e. Street and Number<br><b>205 East Joppa Road Apt. #1905</b>  |  | 10f. Zip Code<br><b>21204</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b><br>College (1-4 or 5+) <b>Unknown</b> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Make</b>  |  |
|   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Hue Hartman</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Fields</b>   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>J. Michael Recher (Guardian)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>300 Allegheny Ave. Towson, Maryland 21204</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gard.</b>  |  | 20c. Location - City or Town, State<br><b>3.31/97 Timonium, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Jeffrey L. Gair</b>  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Md. 21204</b>                                      |  |  |  |
|   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MAYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>A. S. C. V. D.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b> |  | Approximate Interval Between Onset and Death  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Raymond A. Wozniak MD</b>   |  | 29c. License number<br><b>D34184</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/27/97</b>                                  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAYMOND A. Wozniak, PA 7801 YORK RD #300, Towson MD 21204</b>  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 28 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.

5. The fifth part of the report is a list of appendices.

6. The sixth part of the report is a list of figures and tables.

7. The seventh part of the report is a list of footnotes.

8. The eighth part of the report is a list of acknowledgments.

9. The ninth part of the report is a list of abbreviations.

10. The tenth part of the report is a list of symbols.

11. The eleventh part of the report is a list of equations.

12. The twelfth part of the report is a list of diagrams.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 09448

Reg. No.

|  |  |   |  |  |   |  |   |  |
|--|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Joseph Arthur</b>                                |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1997</b> |  | 3. Time of Death<br><b>3:00 pm</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>The Good Samaritan Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |  | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-03-4761</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 2, 1917</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |  |  |   |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>2819 Chesley Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21234</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dispatcher</b>   |   | 16b. Kind of Business/Industry<br><b>Trucking</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas C. Arthur</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Herr</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Sophia J. Arthur / Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2819 Chesley Avenue Baltimore, Md. 21234</b>   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Rosary Cemetery</b>   |  | Date<br><b>4/2/97</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |   |  |
| 21. Signature of Funeral Service Licensee <b>Mark T. Zavoyna</b>   |  |   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck, Inc.<br/>5305 Harford Road Baltimore, Maryland 21214</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CARDIO-PULMONARY ARREST</b><br>Due to (or as a consequence of):<br>b. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>c. <b>ISCHEMIC CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC RENAL FAILURE</b><br><b>GRAM -UE SEPSIS</b>   |  |   |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>J. K. P. DODON</b> MD   |  | 29c. License number<br><b>P10583</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 29 1997</b>                                    |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JACQUES K. P. DODON</b> <b>GOOD SAMARITAN HOSPITAL</b>  |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Rendell</b>   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09449

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James M. Anderson

2. Date of Death  
Month Day Year

March 28 1997

3. Time of Death

0620

4e. Facility Name (If not institution, give street and number)

Church Home Hospital

4b. City, Town, or Location of Death

BALTO. City

4c. County of Death

BALTO. City

5. Social Security Number

401-18-1621

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Sept. 3 1913

9. Birthplace (State or Foreign Country)

TENN

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO. City

10c. City, Town or Location

BALTO. City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

360 Folcroft St.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Long Shoreman

16b. Kind of Business/Industry

I.L.A. Union

17. Father's Name (First, Middle, Last)

William Henry Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Coloney Bell Oxford

19e. Informant's Name/Relationship (Type, Print)

Betty Carter (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1815 E Lombard St. BALTO. MD. 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Memorial Gardens Ann. 31

Delete

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

J. P. Smith

22. Name and Address of Facility

Charlton F. H. 2007 Eastern Ave. BALTO. 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Tongue Cancer, Stage IV

Due to (or as a consequence of):

Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition  
Gastric Ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Navarro Jr. Med. Specialist

29c. License number

D40356

29d. Date signed (Month, Day, Year)

March 28, 1997

30. Name and address of person who completed cause of death (Item 23b) (Type, Print)

MEVELISH NAVARRO MD 100 N. Broadway, BALTIMORE MD. 21231

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

J. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Baltimore, Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 25 is marked "1," show any injury or other traumatic event; the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09450

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD ARNESS</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>26</b> Year <b>1997</b>   |  |   |  | 3. Time of Death<br><b>2:05 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GENESIS ELDERCARE CROMWELL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |  |   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-09-1265</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>7/11/10</b>                   |  | 9. Birthplace (State or Foreign Country)<br><b>MINNESOTA</b>                                |  |
|   | Usual Residence of Decedent  |  |   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>GLEN ARM</b>  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>13203 MANOR ROAD</b>  |  |   |  | 10f. Zip Code<br><b>21057</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3 YEARS</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Superintendent of Melting</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>ARMCO STEEL</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>OLAF ARNESS</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LOUISE BELL</b>   |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARET J. ARNESS WIFE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13203 MANOR ROAD GLEN ARM, MD 21057</b>   |  |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GAR. 3/29/97 COCKEYSVILLE, MD</b>  |  |   |  | 20c. Location - City or Town, State   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Christina L. Kopycz</b>  |  |   |  | 22. Name and Address of Facility<br><b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>  |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Alzheimer's Disease</b><br>Due to (or as a consequence of):  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>YEARS</b>                                |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how Injury occurred   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><b>Fredric S. Sirkis MD</b>  |  |   |  | 29c. License number<br><b>D 22645</b>   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>3/27/97</b>  |  |   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>FREDRIC S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222</b>   |  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 2 is marked other than "natural", or items 23a or 28a-f show any injury or other immediate event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09451

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CONSTANCE BROWER</b>  |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>21:28 PM</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>JOHN HOPKINS BAYVIEW HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>097-24-9357</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 13, 1932</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Dundalk</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>7974 St. Monica Drive</b>  |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 Years</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Human Resource Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Human Resources</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Kenneth Carrighan</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ann Rose Holtzer</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>George K. Brower/Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7974 St. Monica Drive Dundalk, Maryland 21222</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>   |  | 20c. Date<br><b>3/29/1997</b>   |  | 20d. Location - City or Town, State<br><b>Towson, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Johnny L. Gable</b>   |  |
|   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Hypertensive</b><br>e. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dennis J. Chute MD</b>  |  |
|   | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 26, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute MD<br/>111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  |
| To Be Completed by Registrar                  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |  | 33. Date of Death (Month, Day, Year)<br><b>MARCH 25, 1997</b>   |  | 34. Date of Death (Month, Day, Year)<br><b>MARCH 25, 1997</b>  |  | 35. Date of Death (Month, Day, Year)<br><b>MARCH 25, 1997</b>   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

09452

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>OLIVER BIRT</b>  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>21</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>2200pm</b>  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>CHURCH NURSING CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE MARYLAND</b>   |   | 4c. County of Death<br><b>n/a</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>245073327</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth<br>(Month, Day, Year)<br><b>JULY 16, 1913</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>N. CAROLINA</b>  |   |  |
| To Be Completed by<br>Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>n/a</b>   |   | 10c. City, Town or Location<br><b>baltimore</b>  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |
|  | 10e. Street and Number<br><b>100 N. B ROADWAY</b>   |  | 10f. Zip Code<br><b>21231</b>   |   | 10g. Citizen of What Country?<br><b>united states</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b>   |  |   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 th</b> College (1-4or 5+) <b>-</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |   | 16b. Kind of Business/Industry<br><b>various trades</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>PRICE BIRT</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KATIE</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LORRAINE BIRT</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>917 ABBOTT COURT, BALTIMORE, MD 21201</b>   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>3-28 LANSDOWNE, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>WM. C. MARCH FH.-1101 E. NORTH AVE.</b>  |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ADENO-CARCINOMA OF STOMACH</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>CHRONIC RENAL INSUFFICIENCY</b>  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|  |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  |   |  |   |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |
| 29b. Signature and title of certifier<br> <b>Rifat Mahmud MD.</b> |   | 29c. License number<br><b>D44073</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH-21-1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>CHURCH HOSPITAL BALTIMORE MARYLAND, Rifat Mahmud MD</b>   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |   | 32. Registrar's Signature<br> |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 09453

Items: 20a,b,c per F.H. G-747 5/23/97 reb Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY L. BELL SR.

2. Date of Death  
Month Day YearMARCH 23<sup>rd</sup> 1997

3. Time of Death

02 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

RAVENWOOD NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

243-50-3548

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

January 10, 1931

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

501 West Franklin Street

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transporting

17. Father's Name (First, Middle, Last)

Eugene Bell

18. Mother's Name (First, Middle, Maiden Surname)

Annie Speight

19a. Informant's Name/Relationship (Type, Print)

Joseph Bell/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2811 Keyworth Avenue, Baltimore, MD 21215

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of  
cemetery, crematory or other place)

EVERETTS CEMETERY

Date

3/29/97

20c. Location - City or Town, State

WILLIAMSTON, NC

21. Signature of Funeral Service Licensee

Joseph B. Van Sant/DVR

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. MYOCARDIAL INFARCTION  
Due to (or as a consequence of):

MINUTES

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

ALCOHOLIC CARDIOMYOPATHY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M. Vasanthakumaran MD

29c. License number

D42510

29d. Date signed (Month, Day, Year)

03/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. VASANTHAKUMARAN MD

821. N. EUTAW ST. #407 MD 21201

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

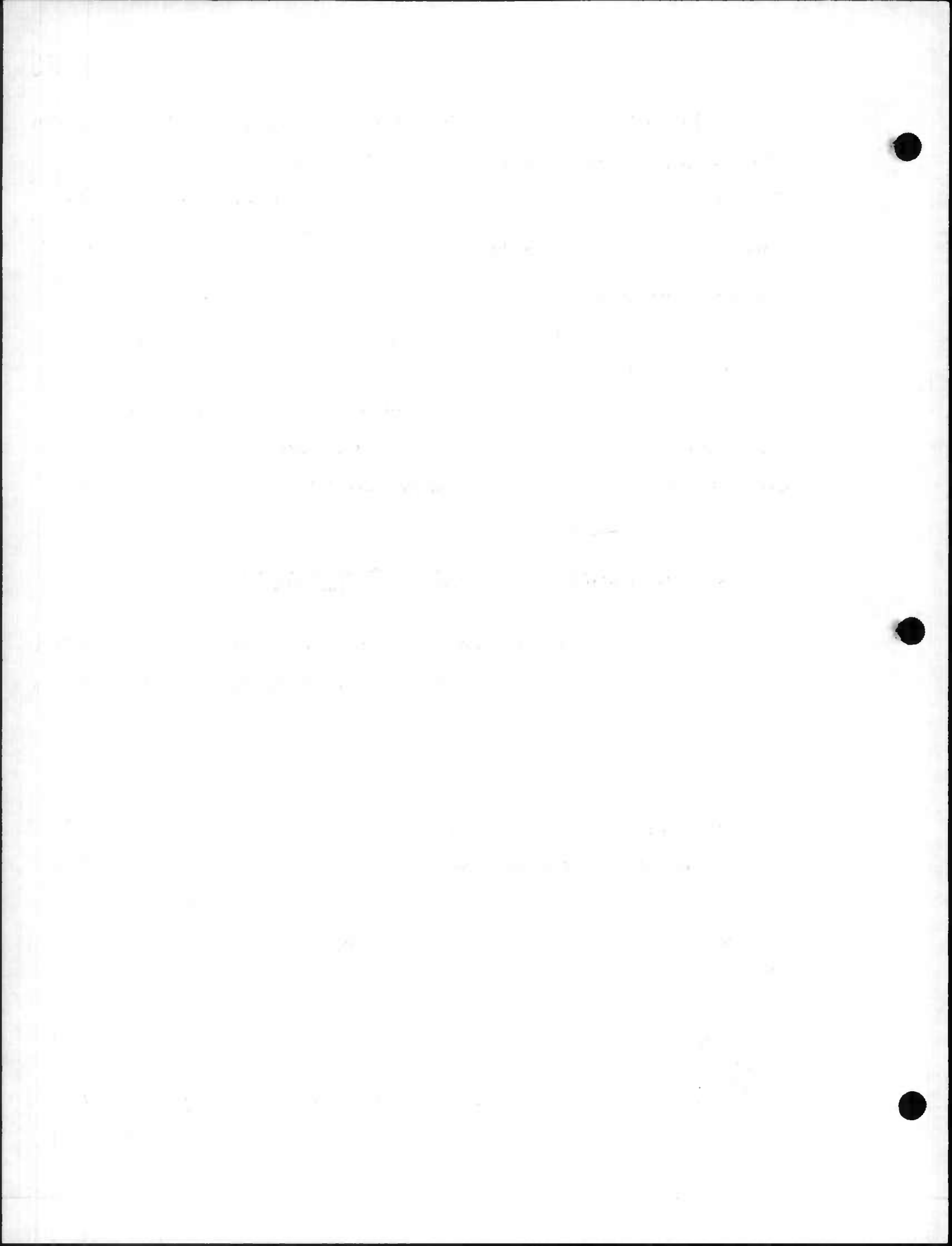
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09454

|   |   |   |   |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|---|---|---|---|--|--|--|---|--|---|----|---------------|----------------------------------|---|----|------------------|----------------------------------|-----------------|----|--|----------------------------------|--|----|--|----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Casaundra Burley</b>   |   |   |  | 2. Date of Death<br>Month <b>03</b> Day <b>24</b> Year <b>97</b>   |  | 3. Time of Death<br><b>8:20pm</b>                                       |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>NA</b>  |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-54-4627</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>12-24-48</b>                  |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>n'a</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                         |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 10e. Street and Number<br><b>2519 E. HOFFMAN STREET</b>  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 10f. Zip Code<br><b>21213</b>   |   |   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 th</b> College (1-4or 5+) <b>DIETARY</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |  | 16b. Kind of Business/Industry<br><b>JOHNS HOPKINS HOSP</b>  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN DRAKE</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET THOMPSON</b>  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>KATASHA BURLEY</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2519 E. HOFFMAN ST., BALTIMORE.MD 21213</b>  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |  | Date<br><b>3-28</b>  |  | 20c. Location - City or Town, State<br><b>LANSDOWNE.MD</b>              |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland</b><br><b>WM.C. March FH 1101 E. North Avenue 21202</b>   |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Sepsis</b></td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death<br/><b>3 days</b></td> </tr> <tr> <td>b.</td> <td><b>Cirrhosis</b></td> <td>Due to (or as a consequence of):</td> <td><b>10 years</b></td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Sepsis</b> | Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>3 days</b> | b. | <b>Cirrhosis</b> | Due to (or as a consequence of): | <b>10 years</b> | c. |  | Due to (or as a consequence of): |  | d. |  | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.  | <b>Sepsis</b>   | Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><b>3 days</b>                |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | b.  | <b>Cirrhosis</b>  | Due to (or as a consequence of):  | <b>10 years</b>  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | c.  |   | Due to (or as a consequence of):  |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   | d.  |   | Due to (or as a consequence of):  |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
|   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>Res-000</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3/24/97</b>  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John C. Isaac, M.D. 600 North Wolfe Street Baltimore, Maryland</b>   |   |   |   |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |   |    |               |                                  |   |    |                  |                                  |                 |    |  |                                  |  |    |  |                                  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 09455

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bonnie

Bannister

2. Date of Death

Month Day Year

March 27, 1997

3. Time of Death

3:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Villa N.C.

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore, Maryland

5. Social Security Number

175-07-6367

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

104 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

09/20/1892

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6910 Carroll Highlands Rd.

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

II

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Farley Forbes

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Hartson

19a. Informant's Name/Relationship (Type, Print)

Bonnie C. Aracil/Grand Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6910 Carroll Highlands Rd. Eldersburg, MD. 21784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

3/29/97

20c. Location - City or Town, State

Beltsville, MD.

21. Signature of Funeral Service Licensee

Philly State

22. Name and Address of Facility

Sterling Ashton Funeral Home, Inc.  
736 Edmondson Ave. Baltimore, MD. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Colon Obstruction

Due to (or as a consequence of):

c. Cancer of the colon

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

BMD

29c. License number

028236

29d. Date signed (Month, Day, Year)

March 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorian S St. Martin MD 5911 Old Frederick Rd Balt MD 21229

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

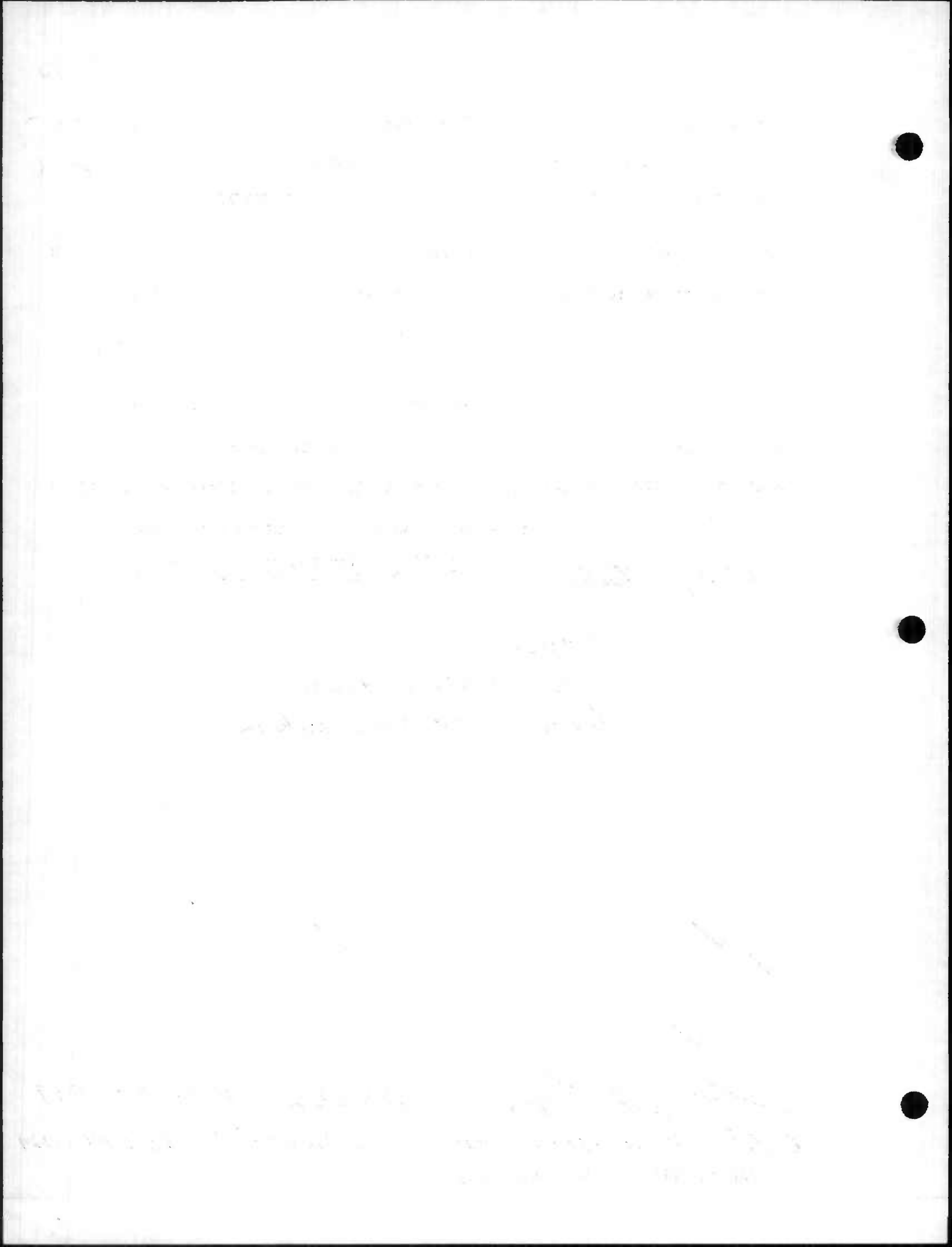
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09456

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |  |  |
|--|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Geraldine Elmira Crawford</b>  |  |   |   | 2. Date of Death<br>Month <b>03</b> Day <b>24</b> Year <b>97</b>   |  | 3. Time of Death<br><b>12:15pm</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6401 Loch Raven Blvd.</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-16-8077</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |  | 8. Date of Birth<br>Month <b>03</b> Day <b>05</b> Year <b>21</b>   |  |
|  | 10e. State<br><b>MD</b>   |  | 10b. County<br><b>n'a</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br><b>6401 LOCH RAVEN BLVD. apt.</b>   |  |   |   | 10f. Zip Code<br><b>21239</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+) <b>-</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>cashier</b>   |   | 16b. Kind of Business/Industry<br><b>BALTIMORE CITY SCHOOL SYSTEM</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JAMES GRIER</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JENNIE LEE</b>   |  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>GEORGE CRAWFORD</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3223 BRENDAN AVENUE, BALTIMORE, MD 21213</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GRRISON FOREST VA CEM. 3-28 OWINGS MILLS.MD</b>  |   | Date   |  | 20c. Location - City or Town, State  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland</b><br><b>WM.C.March FH 1101 E. North Avenue 21202</b>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Possible acute myocardial infarction</b><br>Due to (or as a consequence of):<br><b>coronary artery disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension &amp; Cerebrovascular disease</b><br><b>Polyneuropathy</b> |  |   |   |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension &amp; Cerebrovascular disease</b><br><b>Polyneuropathy</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |  |  |  |
|  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |  |  |
| State Registrar  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |   |   | 29c. License number<br><b>D10152</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/25/97</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>419 Redwood St. Baltimore, MD</b>  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>              |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i> |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09457

|   |   |  |   |  |  |  |   |  |  |  |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>PAUL DENNIS CARTER</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> Year <b>1997</b>  |  |   |  | 3. Time of Death<br><b>21:16</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  |   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-44-8209</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 25, 1945</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent   |  |   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Arbutus</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 10e. Street and Number<br><b>1070 Elm Road</b>   |  | 10f. Zip Code<br><b>21227</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>Groco</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Carter</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Harrison</b>  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Tammy Pope (Daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1000 Francis Ave. Baltimore, MD 21227</b>  |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>3-28-97 Woodlawn, Maryland</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>John K. Anley</b>   |  |   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Rd. Randallstown, MD 21133</b>  |  |   |  |  |  |
|   | 23a. Pertinent to the disease, or complications that caused the death. Do not antart the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.<br><br>e. <b>myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>c. <b>diabetes mellitus</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><b>40 minutes</b><br><b>10 years</b><br><b>20 years</b>  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |  |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                       |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                  |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>John Falck MD</b>   |  | 29c. License number<br><b>D47353</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 25, 1997</b>                                |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jon Falck MD ST. AGNES HOSPITAL BALTIMORE MARYLAND 21229</b>   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09458

Reg. No.

|  |  |   |  |   |   |  |  |  |
|--|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>FELICIA Teresa CALOGERO</b>                         |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MARCH 27 1997</b>  |  | 3. Time of Death<br><b>10:04A.M</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b> |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>009-20-3715</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 12, 1934</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Vermont</b> |
|  | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Randallstown</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>3809 Offutt Road</b>  |  |   |  | 10f. Zip Code<br><b>21133</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |   |  | 16b. Kind of Business/Industry<br><b>Marriott Corp.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Stephen Sapinski</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Sklodowski</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Albert P. Calogero</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3809 Offutt Road Randallstown, MD 21133</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Family Ch. Cemetery 3/31</b>  |   | 20c. Location - City or Town, State<br><b>Randallstown, MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Stephen M. Jenkins</i>   |  |   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>  |   |  |  |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Hypertensive Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death               |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |  |   |  |   |   | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                          |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Stephen A. Radentz MD</i>  |  |   |  | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 28, 1997</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Stephen S. Radentz MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |   |  | 32. Registrar's Signature<br><i>Juba Davidson-Randall</i>   |   |  |  |  |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0026

permit. Pages 1 and 2 should be filed within 72 hours after death, with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural causes," item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at office.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09459

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alfred W. DeLong

2. Date of Death

Month

Day

Year

March 9, 1997

3. Time of Death

10:43pm

4a. Facility Name (If not institution, give street and number)

Carnell County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

212-32-3042

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
January 5, 1903

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Unknown

10b. County

Unknown

10c. City, Town or Location

Unknown

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

Unknown

10f. Zip Code

Unknown

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Unknown Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Professor

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Preston A. DeLong

18. Mother's Name (First, Middle, Maiden Surname)

Daisy May Setley

19a. Informant's Name/Relationship (Type, Print)

Suzanne DeClerca/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1201 Solana Road #3, Naples, Florida 33940

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant/DVR

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street

Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypotension  
Due to (or as a consequence of):

1 hr

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cyan/ascu

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37444

29d. Date signed (Month, Day, Year)

March 10th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Alexander Olegovich Eshen 1425 Liberty Rd Suite 203, Eldersburg, MD 21784

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

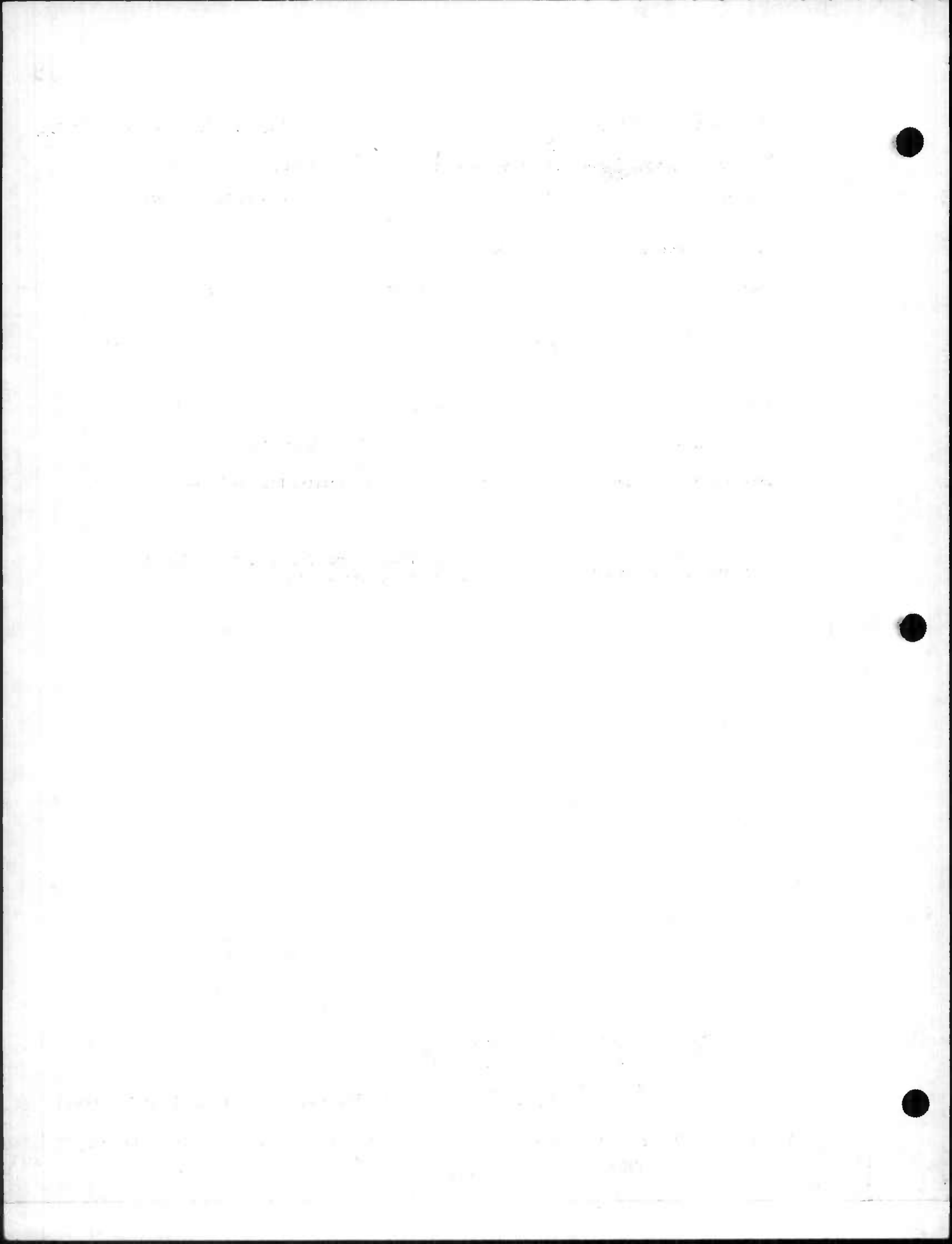
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09460

Certificate of Death

Reg. No.

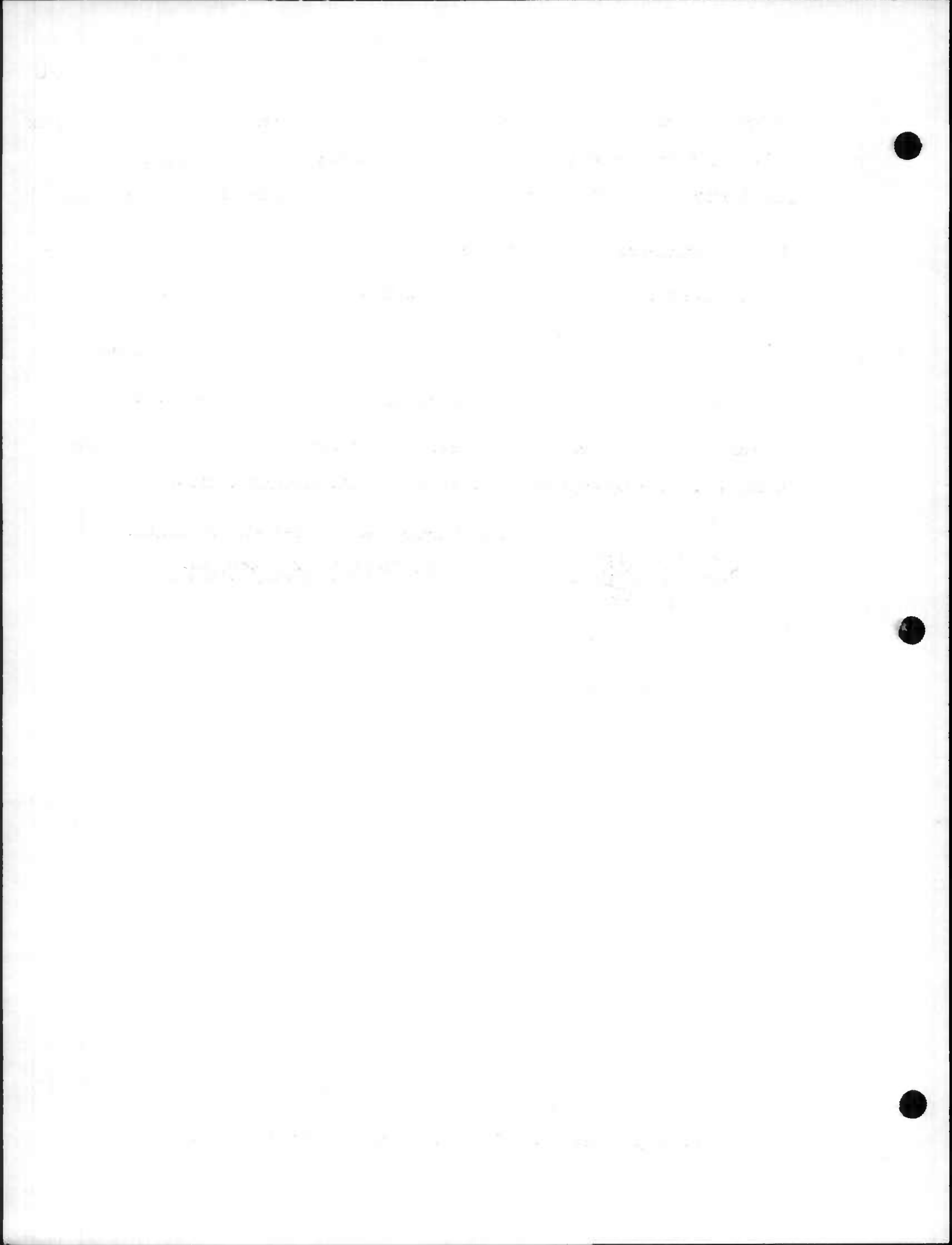
|   |  |  |   |   |  |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mary Tennyson Duncan   |  |   |   | 2. Date of Death<br>Month Day Year<br>March 26 1997  |  | 3. Time of Death<br>2:45 PM  |  |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>Dulaney Towson Nursing Home  |  |   |   | 4b. City, Town, or Location of Death<br>Towson   |  | 4c. County of Death<br>Baltimore   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-30-7937   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>90 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month Day Year<br>July 18 1906 | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |  |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10e. State<br>Md.  | 10b. County<br>Baltimore   |   | 10c. City, Town or Location<br>Towson   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br>111 West Rd.   |  |   | 10f. Zip Code<br>21204  |  | 10g. Citizen of What Country?<br>USA               |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Wilbur T. Hartley   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emily Penn  |  |  |  |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br>Carolyn R. Lazzaro/Daughter  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>42 Alanbrooke Ct. Towson, Md. 21204   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Co.   |   | Date<br>3-28-97  |  | 20c. Location - City or Town, State<br>Towson, Md.   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204  |  |  |  |  |  |
|   | 23a. Pert 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Dehydration</u><br>Due to (or as a consequence of):<br>b. <u>Renuria</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M                           |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28d. Describe how injury occurred   |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |  |  |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 29b. Signature and title of certifier<br>   |  |  |  |  |  |  |
| 29c. License number<br>D 30661  |  |  |   | 29d. Date signed (Month, Day, Year)<br>March 26 1997  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Sireesh K. Tripuraneni, Md. 5670 B The Alameda Baltimore, Md. 21239   |  |  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 31 1997  |  |  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

State  
Registrar



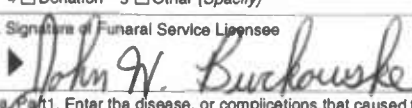
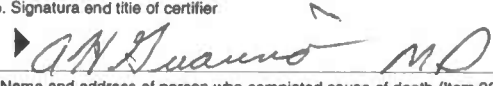
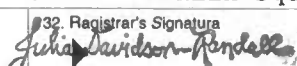
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09461

|  |  |  |  |   |   |   |                                 |  |  |  |
|--|--|--|--|---|---|---|---------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Burnie EDMAN</b>  |  |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1997</b> |   |                                 |  | 3. Time of Death<br><b>1:40 am</b>                 |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>               |   |                                 |  | 4c. County of Death<br><b>Baltimore</b>            |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>232-05-7645</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                      |   | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.                     |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 26, 1918</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>           |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b> |  | 10c. City, Town or Location<br><b>Middle River</b> |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>114 Conestoga Rd.</b>  |   | 10f. Zip Code<br><b>21220</b>   |                                 | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>College</b>   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mill Wright</b>  |  | 16b. Kind of Business/Industry<br><b>Steel Co.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Franklin Edman</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie Davis</b>  |                                 | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald Edman (SON)</b>  |  |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>114 Conestoga Rd. Middle River, Md. 21220</b>                              |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evergreen South Cemetery 4/2/1997</b>  |   | 20c. Location - City or Town, State<br><b>Parkersburg, W. VA.</b>   |                                 | 21. Signature of Funeral Service Licensee<br>  |  |  |
| 22. Name and Address of Facility<br><b>Bruzdinski Funeral Home P.A.<br/>1407 Old Eastern Avenue Essex, Md. 21221</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pneumonia</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  | Approximate interval Between Onset and Death<br><b>5 days</b>   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                 | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                 | 28a. Date of Injury (Month, Day Year)  |  |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                 | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D46673</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1997</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anthony Guarino MD 9000 Franklin Square Drive Baltimore, Maryland 21237</b>  |                                 | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |  |
| 32. Registrar's Signature<br>   |  |  |  |   |   |   |                                 |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

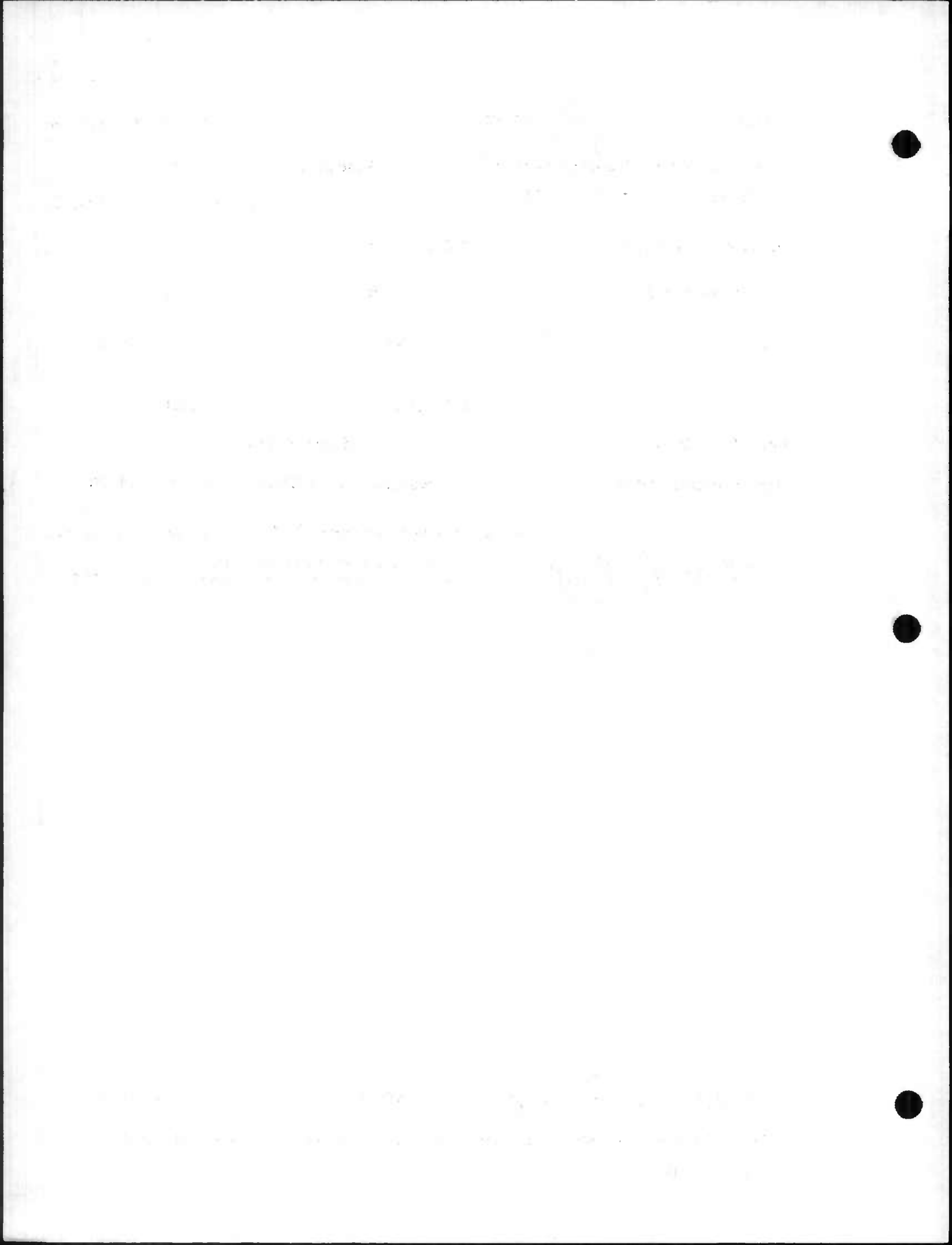
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09462

Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |   |
|---|--|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Alexander L. Falls, Jr.</b>   |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>11:53pm</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>246-10-0623</b>  | 6. Sex<br><b>MALE</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec. 24, 1919</b>   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>       |
|   | Usual Residence of Decedent  |   |   |   |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Owings Mills</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|   | 10e. Street and Number<br><b>41 B Tahoe Circle</b>   |   |   | 10f. Zip Code<br><b>21117</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+) <b></b>  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Machinist</b>            |  | 16b. Kind of Business/Industry<br><b>Machine Factory</b>   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Alexander Lathan Falls, Sr.</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Spencer</b>  |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Janice Yingling</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4733 Alesia Rd., Millers, Md. 21102</b> |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cem. March 31, 1997</b>                              |   | 20c. Location - City or Town, State<br><b>Owings Mills, Md.</b>  |  |   |
|   | 21. Signature of Funeral Service Licenses<br><b>H. J. Eckhardt</b>   |   |   | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel<br/>11605 Reisterstown Rd., Owings Mills, Md. 21117</b>                      |  |  |   |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |   |
|   | <div> <div>Immediate Cause (Final disease or condition resulting in death)</div> <div>a. <b>pneumonia</b><br/>Due to (or as a consequence of):</div> <div>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</div> <div>b. Due to (or as a consequence of):</div> <div>c. Due to (or as a consequence of):</div> <div>d. Due to (or as a consequence of):</div> </div> |   |   |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>coronary artery disease<br/>cirrhosis, diabetes, osteomyelitis</b>   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Usha Sunkara MD</b>   |   | 29c. License number<br><b>A5240-231us</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 27, 1997</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>USHA SUNKARA, Sinai Hospital</b>   |  |   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |   |  |  |   |

Baltimore, Maryland 21215-5030  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09463

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna

2. Date of Death

Month  
MarchDay  
25<sup>th</sup>Year  
1997

3. Time of Death

4:25 PM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

212-26-6705

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

6. Date of Birth

(Month, Day, Year)  
05-17-10

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

38-A Winters Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

4yrs.

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Music Teacher

16b. Kind of Business/Industry

Facilities

17. Father's Name (First, Middle, Last)

John Frank Scott

18. Mother's Name (First, Middle, Maiden Surname)

Amy Barnes

19a. Informant's Name/Relationship (Type, Print)

Diantha Mansur

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2500 Knights Road Apt#4001 benSalem, Pa.3450 19020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)


20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem. Pk. Cem. 03-31-97 Randallstown, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Baltimore, Maryland

WM.C. March FH 1101 E. North Avenue 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Myocardial anoxia

Approximate Interval Between Onset and Death

10+ minutes

Due to (or as a consequence of):

hypertension

years

Due to (or as a consequence of):

insulin dependent diabetes

years

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident

atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 13006

29d. Date signed (Month, Day, Year)

25 March 97

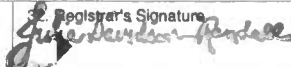
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Powell 101 W. Read St. Baltimore 21201

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09464

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bernarda S. Gulla

2. Date of Death

Month Day Year  
March 29, 1997

3. Time of Death

1906 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

220-88-6919

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 20, 1906

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

324 Bryanstone Road

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Oriental

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Vincente Serquina

18. Mother's Name (First, Middle, Maiden Surname)

Marciana DeCruz

19a. Informant's Name/Relationship (Type, Print)

Ester S. Mejia

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

324 Bryanstone Rd., Reisterstown, Md. 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All Saints Cemetery April 2, 1997 Reisterstown, Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

H. Schlandt

22. Name and Address of Facility

Eckhardt Funeral Chapel  
11605 Reisterstown Rd., Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Adult Onset Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

039050

29d. Date signed (Month, Day, Year)

3/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1838 Green Tree Rd Baltimore MD 21208

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Rendall

State  
Registrar

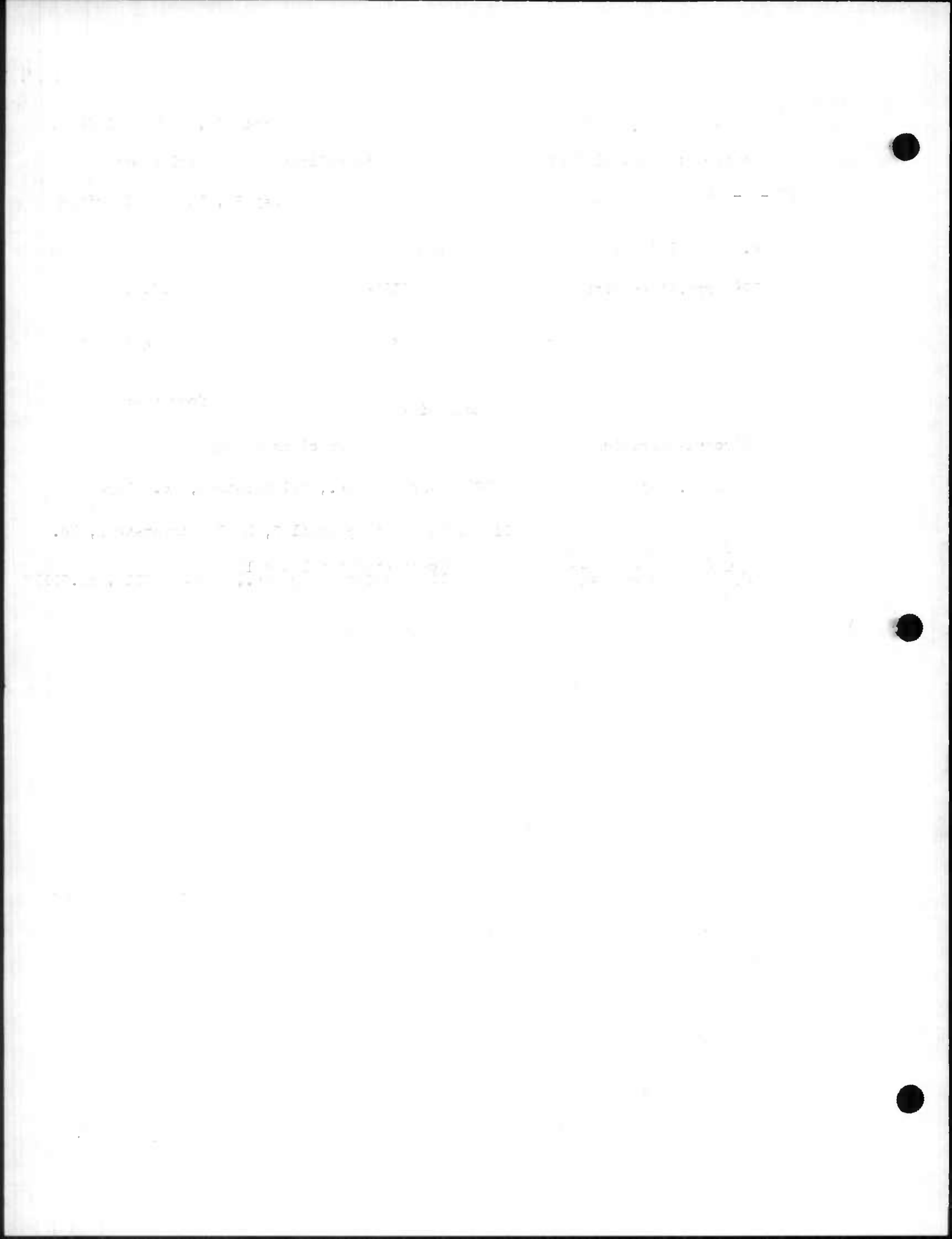
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0026  
permit. Pages 1 and 2 should be filed with the death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09465

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Herman H. Gwinn</b>                              |   |  |  | 2. Date of Death<br>Month <b>03</b> Day <b>23</b> Year <b>97</b> |  | 3. Time of Death<br><b>6:42pm</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>         |  | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>232-34-2522</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 21, 1929</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10e. State<br><b>Md.</b>  |   | 10b. County<br><b>Na</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1905 E. Lanvale Street</b>   |   |   |  | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>NA</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction</b>   |  |  | 16b. Kind of Business/Industry<br><b>Sparrows Point</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William R. Gwinn</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Lee</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Eunice Buie</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21213</b><br><b>1905 E. Lanvale Street 2nd. Fl. Balto. Md.</b>                              |  |  |  |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cem. 03-28 Owings Mills, Md.</b>  |  |  | 20c. Location - City or Town, State                              |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility <b>Baltimore, Maryland</b><br><b>WM.C. March FH 1101 E. North Avenue 21202</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>arteriosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____ |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>0</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28e. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |  |  |  |
| 29b. Signature and Title of certifier<br>   |   | 29c. License number<br><b>D 30854</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>March 25, 1997</b>   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Gabor Kelen, Professor and Chair, Johns Hopkins Emergency Medicine</b>   |   | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  |  |  |  |  |  |
| 32. Registrar's Signature<br>   |   |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 opart I, 27, 28a-f per MEO G-745 3/31/97 <sup>rep</sup> Certificate of Death

Reg. No.

97 09466

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BOBBY ALLEN GAMBINO</b>  |  |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>24</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>0045AM</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1304 NORTH CHESTER STREET</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>424-78-7786</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>APR 10, 1956</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>AL</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>EDGEWATER</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |  | 10e. Street and Number<br><b>201 CADLE AVENUE</b>  |  | 10f. Zip Code<br><b>21106</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                       |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b> |  | 16b. Kind of Business/Industry<br><b>AUTOMOBILE</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HERMAN J. FIELDING</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VERA TEDDER</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>HERMAN J. FIELDING, FATHER</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>304 GOLDENROD AVE. Gadsden, AL. 35901</b>     |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RAINBOW CEMETERY</b>                            |  | Data<br><b>3-27</b>   |  | 20c. Location - City or Town, State<br><b>GADSDEN, AL</b>               |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>STERLING ASHTON FUNERAL HOME, INC.<br/>736 EDMONDSON AVE., BALT. MD 21228</b>                              |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b><br><b>a. NARCOTIC AND ALCOHOL INTOXICATION</b><br>Due to (or as a consequence of):<br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |  |  |  |   |  |   |  |
|   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br><b>3/23/97</b>   |  | 28b. Time of Injury<br><b>unknown</b> M                      |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>House</b>  |   | 28d. Describe how injury occurred<br><b>Unknown</b>  |  |  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1304 N. Chester St. Baltimore, Md.</b>   |   |  |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 24, 1997</b> |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Allen, MD 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |   | 32. Registrar's Signature<br>   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09467

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Regina Geppi

2. Date of Death

March 27, 1997

3. Time of Death

12:30am

4a. Facility Name (If not institution, give street and number)

Alice Manor Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

-----

Funeral  
Director

5. Social Security Number

212-05-8156

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
11/14/1909

9. Birthplace (State or Foreign Country)

Balto, MD

Usual Residence of Decedent

10a. State  
Md

10b. County

-----

10c. City, Town or Location

Baltimore

10d. Inside City Limits

4 ☒ Yes 2 ☐ No

10e. Street and Number

1320 James Street

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

XXX Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

A&amp;P Grocery Store

17. Father's Name (First, Middle, Last)

Salvatore Unk

18. Mother's Name (First, Middle, Maiden Surname)

Emma Unk

19a. Informant's Name/Relationship (Type, Print)

Nancy Archer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2021 Wisper Woods Way Balto, MD 21244

20e. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

4/1

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss Funeral Home

3631 Falls Rd. Balto, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):b. Pneumonia  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

X ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23076

29d. Date signed (Month, Day, Year)

3-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard L. Diamond, MD.

3730 Falls Rd. Balto. MD 21211

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a certifies show any injury or other traumatic event, the Medical Examiner must be notified at once.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09468

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice B. Haines

2. Date of Death

March 21 1997

Day Year

3. Time of Death

11:01 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

1000 Franklin Avenue Apartment 1005

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

212-16-2570

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 29, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1000 Franklin Ave Apt. 1005

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Zacharey Bulkowski

18. Mother's Name (First, Middle, Maiden Surname)

Zophia Odachowski

19a. Informant's Name/Relationship (Type, Print)

Daniel Wisniewski (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Homeland Road Middle River, Maryland 21220

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

3/25/97

20c. Location - City or Town, State

Baltimore County, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home PA

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Atherosclerotic Cardiovascular disease

Approximate Interval Between Onset and Death

&gt; 5 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32939

29d. Date signed (Month, Day, Year)

3/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory Pokrywka M.D. 2914 East Joppa Rd Baltimore Md 21234

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09469

|  |   |  |   |                                |   |
|--|---|--|---|--------------------------------|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Marlyn Handlir</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>25</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>530pm</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland General Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |                                | 4c. County of Death<br><b>n/a</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>unknown</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 5, 1940</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |   |
| To Be Completed by Funeral Director  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>n/a</b>   |                                | 10c. City, Town or Location<br><b>Baltimore</b>   |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1108 Sterrett St.</b>  |                                | 10f. Zip Code<br><b>21230</b>   |
|  | 10g. Citizen of What Country?<br><b>United States</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |                                |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laboratory Technician</b>   |                                | 16b. Kind of Business/Industry<br><b>Optical Laboratory</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph J. Handlir</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Wilson</b>  |                                |   |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Dolores Althoff / Aunt</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2475 Woodcroft Rd., Baltimore, MD 21234</b>   |                                |   |
|  | 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |                                | Date<br><b>3/29/97</b>  |
|  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Stephen D. Lohrmann</b>   |                                |   |
|  | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>   |  |   |                                |   |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Sepsis</b><br>Due to (or as a consequence of):<br><b>b. Liver Cirrhosis</b><br>Due to (or as a consequence of):<br><b>c. Renal Failure</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |                                | Approximate Interval Between Onset and Death  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                |   |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>   |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |   |
|  | 29b. Signature and title of certifier<br><b>Dr. Ignatovich MD</b>   |  | 29c. License number<br><b>89271</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>3/25/97</b>   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>K.N.A. GEN. MED. H. c/o Maryland General Hospital</b> |   |  |   |                                |   |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |                                |   |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09470

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Katherine Hale

2. Date of Death

Month

Day

Year

March 26, 97

3. Time of Death

6:16 pm

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Rentalstown

4c. County of Death

Baltimore

5. Social Security Number

212-32-1639

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Mar. 4, 1912

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1708 Hill Drive

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Curtis Parks

18. Mother's Name (First, Middle, Maiden Surname)

Addie Cornett

19a. Informant's Name/Relationship (Type, Print)

Mrs. Nancy Deitz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1708 Hill Drive Baltimore, MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lorraine Park Cem.

Date

3/29

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Stephen M Jenkins

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. J. Lee

29c. License number

H43974

29d. Date signed (Month, Day, Year)

March 26, 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Loring Byers, Loring Byers Funeral Directors, Inc., Rentalstown, Md

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



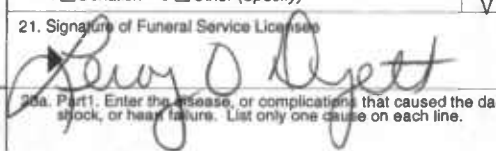
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09471

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>William Hilliard</b>  |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>25</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>7:45pm</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3716 Woodridge Road</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>227-22-9476</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>May 6 1928</b>                         |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>                                  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>3716 Woodridge Road</b>  |  | 10f. Zip Code<br><b>21229</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>foreman</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |  | 16b. Kind of Business/Industry<br><b>manufacturing</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Edwards</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>M ary Etta Hilliard</b>  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mozzelle Cox</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>141 South Munn Avenue Newark NJ</b>  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshelle Cemetery</b>  |  | Date<br><b>3/29</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore</b>                          |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Leroy O Dyett and Son Funeral Home</b><br><b>4600 Liberty Heights Ave Balto. Md 21207</b>   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. metastatic colon cancer</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                 |  |  |   |  |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |   |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>                            |  |  |   | 29c. License number<br><b>044944</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/27/97</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stan Walker - Union Memorial Hospital Baltimore Md 21218</b> |  |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  |  |   | 32. Registrar's Signature<br> |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than Natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09472

|   |   |   |  |   |   |  |  |   |
|---|---|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Ernest Hagenbuch</b>                      |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1997</b> |  | 3. Time of Death<br><b>10:00 AM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1613 Turkey Point Road</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Essex</b>                  |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>187-16-8691</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 23, 1918</b>                                    |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                 |   |  |   |   |  |  |   |
| Usual Residence of Decedent   |   |   |  |   |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Essex</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1613 Turkey Point Road</b>   |   |   |  | 10f. Zip Code<br><b>21221</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sheet Metal Maintenance</b>   |   |  | 16b. Kind of Business/Industry<br><b>Stove &amp; Hardware Co.</b>                              |   |
| 17. Father's Name (First, Middle, Last)<br><b>Clayton R. Hagenbuch</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Buttner</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Concetta Hagenbuch (WIFE)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1613 Turkey Point Road Essex, Md. 21221</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>   |   | Date<br><b>4/1/1997</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore City, Md.</b> |
| 21. Signature of Funeral Service Licensed<br><i>John N. Buckowski</i>   |   |   |  | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home P.A.<br/>1407 Old Eastern Avenue Essex, Md. 21221</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br><b>Lymphoma</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>1990-97</b>    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                                 |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29b. Signature and title of certifier<br><i>Ronald Attanasio</i>  |   | 29c. License number<br><b>D-2 28097</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 31, 1997</b>      |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>1012 OLD NORTH PT ROAD BALT, MARYLAND</b>  |   |   |  |   |   |  |  | <b>R. ATTANASIO MD</b>  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |   |   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

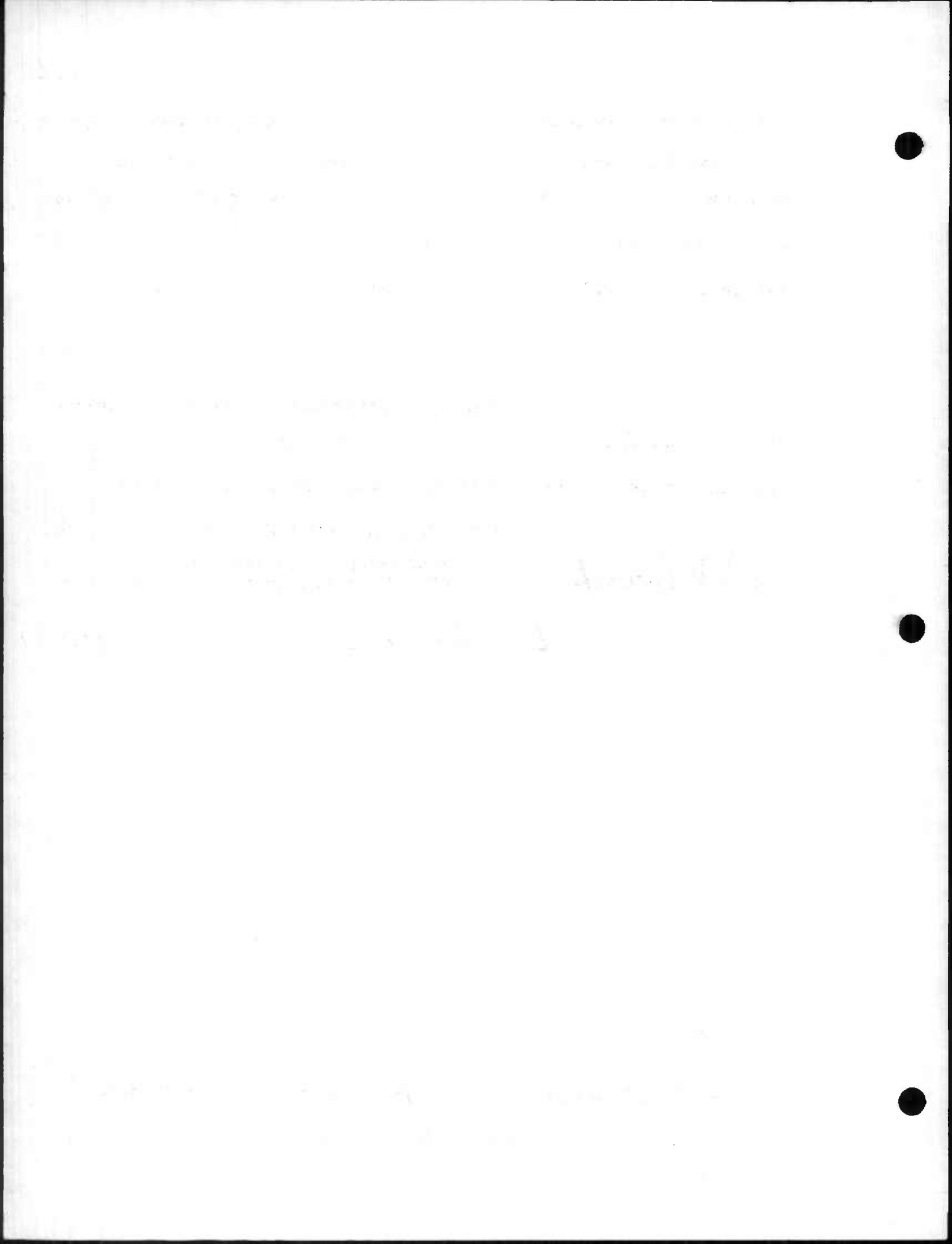
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09473

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |   |   |  |
|---|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Donald Jackson</u>   |  |   |  | 2. Date of Death<br>Month <u>3</u> Day <u>26</u> Year <u>97</u>  |   | 3. Time of Death<br><u>10:42pm</u>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Mercy Medical Center</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |   | 4c. County of Death   |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>217-54-1143</u>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>45</u> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><u>MAY 22, 1951</u>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>BALTO. MARYLA</u>  |  | 10a. State<br><u>Md.</u>  |  | 10b. County<br><u>N/A</u>  |   | 10c. City, Town or Location<br><u>BALTIMORE</u>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10a. Street and Number<br><u>2861 MAYFIELD AVENUE</u>   |  | 10f. Zip Code<br><u>21213</u>  |   | 10g. Citizen of What Country?<br><u>U.S.A.</u>                          |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12th grade</u><br>College (1-4 or 5+) <u>2 years</u>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>HIGHWAY MAINTANENCE</u>           |  | 16b. Kind of Business/Industry<br><u>CITY OF BALTIMORE</u>   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>ROBERT JACKSON</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>GERTRUDE MALONE</u>  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>ROBERT JACKSON/ SON</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1038 ELLICOTT DRIVE, BALTO., Md. 21216</u>   |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>MT. ZION CEMETERY</u>  |  | 20c. Location - City or Town, State<br><u>4/2/97 LANDSDOWNE, Md.</u>   |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Joseph R. Watling Jr.</u>   |  |   |  | 22. Name and Address of Facility<br><u>UNITY FUNERAL HOME, 108 W. NORTH AVE, 21201</u>   |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><u>Sepsis</u><br>Due to (or as a consequence of):<br><br><u>Pneumonia</u><br>Due to (or as a consequence of):<br><br><u>AIDS</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |   |  |
|   | Approximate Interval Between Onset and Death<br><u>4 hours</u><br><u>3 days</u><br><u>years</u>   |  |   |  |  |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Panding investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |   |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><u>Laura Pimentel, MD</u>  |   |  |   | 29c. License number<br><u>D40363</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>3/28/97</u>                                       |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Laura Pimentel, MD, Mercy Medical Center, Baltimore, MD</u>  |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>MAR 31 1997</u>   |   |  |   | 32. Registrar's Signature<br><u>John Davidson-Randall</u>                    |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09474

Items 20b, 20c 3-31-97 Film G745 W.H.Per F/H

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |  |  |  |
|--|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Johnson</b>  |   |  |   | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>6:58</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>John Hopkins Bayview Medical Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-24-5466</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 9, 1930</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b> |
|  | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Middle River</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1419 Third Rd.</b>  |  |   |  | 10f. Zip Code<br><b>21220</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Date <b>Aug: 1951</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Tool Maker</b>  |   | 16b. Kind of Business/Industry<br><b>Air Craft</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Johnson</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lola Thomason</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Suzanne Young (DAUGHTER)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>353 Green Aspen Ct. Millersville, Md. 21108</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of)<br><b>Holly Hill Mem. Garden</b>  |  | Date<br><b>3/28/1997</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore County</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Bruzdinski Funeral Home P.A.</b><br><b>1407 Old Eastern Avenue, Essex, Md. 21221</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Adenocarcinoma of lung</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>7 days</b>   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease;</b><br><b>Chronic obstructive airway disease</b>   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                            |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>95012</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>03/26/97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. KULBIR SANDHU</b>   |  |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Johns Hopkins Bayview Medical Center</b><br><b>4940 Eastern Avenue, Baltimore, MD 21224</b>        |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  | 32. Registrar's Signature<br>   |  |   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09475

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ROSIE ORLENA JONES</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:50 A.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>DULANEY TOWSON NURSING CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-26-1489</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>6/19/02</b>                            |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>                             |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>6401 LOCH RAVEN BLVD. APT. 241</b>   |  | 10f. Zip Code<br><b>21239</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>          |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th GRADE</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>DOW LORENZO FANNON</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY ELIZABETH THOMPSON</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>BETTIE HUNT DAUGHTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 WEST SEMINARY AVE. LUTHERVILLE, MD 21093</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GAR.</b>   |  | 20c. Date<br><b>3/28/97</b>  |  | 20d. Location - City or Town, State<br><b>COCKEYSVILLE, MD</b>                   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Christina L. Kopyczuk</i>   |  |   |  | 22. Name and Address of Facility<br><b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multi-system failure.</b><br>Due to (or as a consequence of):<br><b>b. Arteriosclerotic cardiovascular disease yrs.</b><br>Due to (or as a consequence of):<br><b>c. Diabetic Mellitus type II</b><br>Due to (or as a consequence of):<br><b>d. peripheral vascular disease</b> |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dehydration, Electrolyte Imbalance.</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.  |  | 29c. License number<br><b>D-17992</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3/25/97</b>  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KHIM M. TUN. 1006 Taylor Avenue Towson md 21286.</b>   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09476

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAMONT S JOHNSON

2. Date of Death  
Month Day Year

MARCH 28, 1997

3. Time of Death

1:03 A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

VAMHCS FORT HOWARD DIVISION, 9600 North Point Rd, FORT HOWARD

4b. City, Town, or Location of Death

4c. County of Death

BALTIMORE

5. Social Security Number

212 48 0429

6. Sex

1# M 2# F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

8/5/47

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10e. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1# Yes 2# No

10e. Street and Number

1212 W. FRANKLIN ST.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1# Never Married 2# Married

3# Widowed 4# Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1# Yes 2# No

If Yes, Give Year or Dates: 2/68

2/70

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1# Yes 2# No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO

AMERICAN

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

BENJAMIN SPRIGGS

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY URQUHART

19a. Informant's Name/Relationship (Type, Print)

DOROTHY JOHNSON MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1361 CARROLL ST. BALTIMORE, MD. 21230

20e. Method of Disposition

1# Burial 2# Cremation 3# Removal from State

4# Donation 5# Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. VETERAN

Date

4/3/97

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

Leil A. Estep

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. SEPTIC EMBOLI TO LUNGS, CORONARY VESSEL AND BOWELS

Due to (or as a consequence of):

c. BACTERIAL ENDOCARDITIS

Due to (or as a consequence of):

d. PNEUMONIA

Approximate Interval Between Onset and Death  
seconds to minutes

2 hours

1 month

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DRUG ABUSE; HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1# Yes 2# No 3# Probably 4# Unknown

24e. Was an autopsy performed?

1# Yes 2# No

24b. Were autopsy findings available prior to completion of cause of death?

1# Yes 2# No

25. Was case referred to medical examiner?

1# Yes 2# No

Hospital:

1# Inpatient 2# ER/Outpatient 3# DOA

Other:

4# Nursing Home 5# Residence 6# Other (Specify)

27. Manner of Death

1# Natural 2# Accident 3# Suicide 4# Homicide 5# Pending Investigation 6# Could not be determined

28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1# Yes 2# No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1# Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2# Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Marcos Galicia MD

29c. License number

D15698

29d. Date signed (Month, Day, Year)

March 28, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

DR. MARCOS GALICIA, M.D. -- 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

John Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural" for items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09477

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE KIZZIE

2. Date of Death

Month Day Year  
MARCH 27 1997

3. Time of Death

1950 HOURS

4a. Facility Name (If not Institution, give street and number)

St Agnes Hosp

4b. City, Town, or Location of Death

BALTO. MD

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

212-14-2819

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-16-16

9. Birthplace (State or Foreign Country)

GA.

Usual Residence of Decedent

10a. State

MD

10b. County

N.A.

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3901 MONDAMIN AV.

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1943-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th Grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

BARBER

16b. Kind of Business/Industry

BARBER

17. Father's Name (First, Middle, Last)

Dewitt KIZZIE

18. Mother's Name (First, Middle, Maiden Surname)

ALMA SLAUGHTER

19a. Informant's Name/Relationship (Type, Print)

Bertha KIZZIE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3901 MONDAMIN AVE BALTO. MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRISON FOREST CEM

Date

4/2/97

20c. Location - City or Town, State

OWINGS MD. MILLS

21. Signature of Funeral Service Licensee

Joseph B. Locke

22. Name and Address of Facility

Locks Funeral Home 1304 N. Central Ave Baltimore

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. VENTRICULAR FIBRILLATION

72 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

20 years

c. RESPIRATORY FAILURE

72 hours

d. ESOPHAGEAL CARCINOMA

ten months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jonathan Safren MD

29c. License number

MARYLAND D41711

29d. Date signed (Month, Day, Year)

MARCH 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN SAFREN MD 3449 WILKENS AVENUE Suite 300 BALTIMORE, MARYLAND 21229

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours immediately with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09478

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADA LITTLE

2. Date of Death

Month Day Year  
March 28 1997

3. Time of Death

4:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris at Mercy Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

220-12-5168

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01 29 1899

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel Co.

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5904 Belle Grove Road

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10thCollege (1-4 or 5+)  
College16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

Julius Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Johnson

19a. Informant's Name/Relationship (Type, Print)

Julius Little/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 St. Charles Road, Baltimore, Maryland 21225

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland National Cemetery 4/2/97 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensed

[Signature]

22. Name and Address of Facility

William C. Brown Community Funeral Home  
1206 W. North Avenue, Baltimore, Maryland 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Rectal Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 mos

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

STELLA MARIS AT MERCY

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D40480

29d. Date signed (Month, Day, Year)

March 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO J. FERRO, MD

5810 Belair Rd  
Baltimore, MD 21206

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09479

|   |  |  |   |   |  |  |  |  |
|---|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Melvin William Luette Sr.</b>               |  |   |   | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>4:15 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care-Ruxton</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>Ruxton</b>  |  | 4c. County of Death<br><b>Baltimore Co.</b>                                      |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-10-7823</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 15, 1910</b>                     |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>                                  |  |
| Usual Residence of Decedent   |  |  |   |   |  |  |  |  |
| 10e. State<br><b>Maryland</b>   |  |  |   | 10f. Zip Code<br><b>21239</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Payroll Accountant</b>  |   |  | 16b. Kind of Business/Industry<br><b>Bethlehem Steel</b> |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William O. Luette</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine Froelich</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Ronald C. Luette/ Son</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2003 Winford Road Baltimore, Maryland 21239</b> |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corporation</b>  |   | Date<br><b>4/1/97</b>  |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>                   |  |
| 21. Signature of Funeral Service Licensee <b>Mark T. Zavoyna</b><br>  |  |  |   | 22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc.</b><br><b>5305 Harford Road Baltimore, Maryland 21214</b>                    |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Carcinoma of Lung</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br><b>Months</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Carcinoma of Brain</b>   |  |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   |  |  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28d. Describe how Injury occurred                        |  |  |
|   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |   | 29c. License number<br><b>D-12849</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>3-31-97</b>    |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>A.H. GMILADI, MD, 7600 OSLER DR. TOWSON MD 21204</b>   |  |  |   |   |  |  |  |  |
| 31. Date of Death (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at office.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09480

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><i>Robertson Leach</i>  |  |  |  | 2. Date of Death<br>Month <i>March</i> Day <i>28</i> Year <i>1997</i>   |  | 3. Time of Death<br><i>12:20 PM</i>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><i>The Gilchrist Hospice Center</i>   |  |  |  | 4b. City, Town, or Location of Death<br><i>Towson</i>   |  | 4c. County of Death<br><i>Baltimore</i>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><i>218 09 2650</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><i>86</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>Feb. 11, 1911</i>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>   |  | 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>n/a</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><i>5204 Roland Ave</i>   |  | 10f. Zip Code<br><i>21210</i>   |  | 10g. Citizen of What Country?<br><i>United States</i>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Advertising Representative</i>   |  | 16b. Kind of Business/Industry<br><i>Publishing Company</i>   |  | 17. Father's Name (First, Middle, Last)<br><i>Robert Fulton Leach III</i>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Grace Hitchens</i>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Grace Ann Leach / Daughter</i>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>15 Red Hearth Ct., Baltimore, MD 21227</i>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Green Mount Crematory</i>  |  | 20c. Date<br><i>3/29/97</i>  |  | 20d. Location - City or Town, State<br><i>Baltimore, MD</i>   |  | 21. Signature of Funeral Service Licensee<br><i>Stephen D. Lohrmann</i>   |  |
|   | 22. Name and Address of Facility<br><i>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</i>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <i>acute ischemic stroke</i><br>Due to (or as a consequence of):<br><br>b. <i></i><br>Due to (or as a consequence of):<br><br>c. <i></i><br>Due to (or as a consequence of):<br><br>d. <i></i><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><i>7 days</i>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i> |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)<br><i>None</i>  |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>W.A. Riley, MD</i>  |  |
|   | 29c. License number<br><i>025205</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>March 28, 1997</i>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>W.A. Riley GMC 6701 N. Charles St., Balto MD</i>   |  | 31. Data filed (Month, Day, Year)<br><i>MAR 31 1997</i>   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |  | 33. Registrar's Title<br><i>Registrar</i>  |  | 34. Registrar's Address<br><i>21204</i>   |  | 35. Registrar's Phone<br><i></i>  |  |
|   | 36. Registrar's Signature<br><i></i>  |  | 37. Registrar's Title<br><i></i>   |  | 38. Registrar's Address<br><i></i>  |  | 39. Registrar's Phone<br><i></i>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*End-stage renal disease**Hypertension*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09481

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN G. LAVICKA

2. Date of Death

MARCH 28, 1997

Day Year

3. Time of Death

0245

4e. Facility Name (If not institution, give street and number)

Church Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-22-4856

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 26, 1911

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

66 N. Dundalk Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Seigred Stemper

18. Mother's Name (First, Middle, Maiden Surname)

Victoria Drud

19a. Informant's Name/Relationship (Type, Print)

Albert Fleig/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

66 N. Dundalk Ave., Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bohemian National Cemt. 3-31-97 Balto., Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton Funeral Home, Inc.

2134 Willow Spring Rd., Dundalk, Md. 21222

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Hypertensive Heart Disease

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Iron deficiency Anemia

Urinary Tract Infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. David Davidson, M.D. - Specialist

29c. License number

D40356

29d. Date signed (Month, Day, Year)

MARCH 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WENEUSA NAVARRO, MD

20 N. BROADWAY, BALTIMORE, MD. 21231

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

John Davidson-Randall

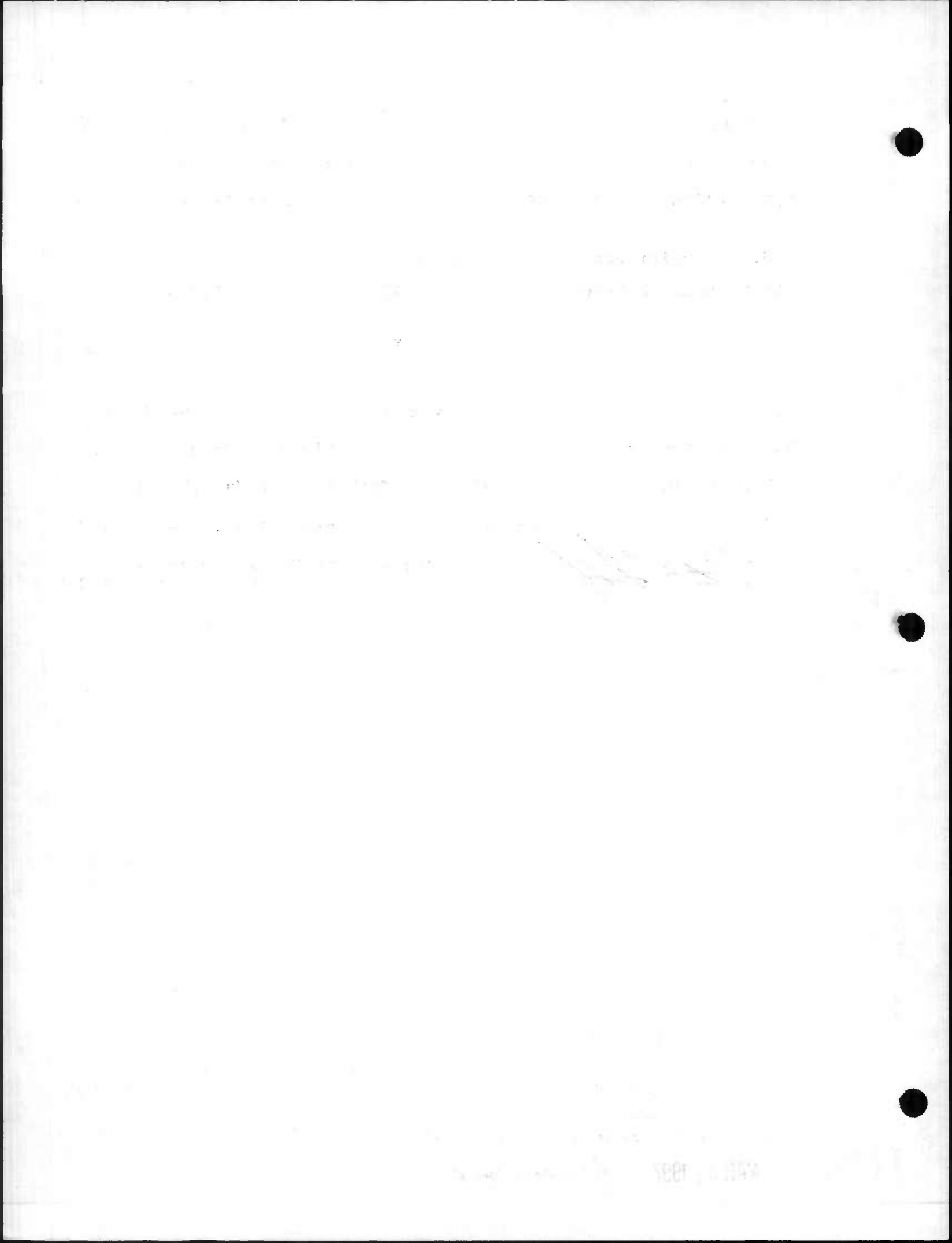
State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09482

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Katherine Miller</b>   |   | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>12:50 P.m.</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-34-4799</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>May 14, 1906</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |
|   | 10e. Street and Number<br><b>313 Kerneway</b>   |   | 10f. Zip Code<br><b>21212</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b><br>College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Dietz</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine McKenry</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Vernon R. Miller (Son)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>89 Eastway Severna Park, MD. 21146</b>        |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4/1/97 Baltimore</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, MD. 21204</b>                                     |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |   |  | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)   |   |   |  |  |
|   | a. <b>Metabolic acidoses</b><br>Due to (or as a consequence of):  |   |   |  | <b>4 days</b>  |
|   | b. <b>Atrial fibrillation</b><br>Due to (or as a consequence of):   |   |   |  | <b>3 days</b>  |
|   | c.<br>Due to (or as a consequence of):  |   |   |  |  |
|   | d.<br>Due to (or as a consequence of):  |   |   |  |  |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic Cardiomyopathy</b>  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |   |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |
| 29b. Signature and title of certifier<br><b>J. Had Toussef M.D.</b>   |   | 29c. License number<br><b>P10584</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>March 28, 1997</b>                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Good Samaritan Hospital 5601 Loch Raven Baltimore, M.D. 21239</b>  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death within the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09483

|  |   |  |  |  |  |   |   |
|--|---|--|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SANDRA LEE MEYER</b>   |  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 27, 1997</b>  |  | 3. Time of Death<br><b>02:45 AM</b>     |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>INTERSTATE 695 WEST OF CHARLES STREET</b>  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b> |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-17-5597</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>22</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)   |
|  | Usual Residence of Decedent   |  | 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Essex</b>   |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>221 Virginia Ave.</b>   |  | 10f. Zip Code<br><b>21221</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bartender</b>  |  | 16b. Kind of Business/Industry<br><b>Tavern</b>  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles J. Meyer</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura French</b>   |  |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kimberly Meyer (Sister)</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6506 Black Head Rd. Baltimore, Md. 21220</b> |  |   |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gdn.</b>  |  | 20c. Location - City or Town, State<br><b>3/29/1997 Baltimore Co. Md.</b>  |   |   |
|  | 21. Signature of Funeral Service Licensee<br><i>John Burkowski</i>  |  | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home P.A.<br/>1407 Old Eastern Ave. Essex, Md. 21221</b>  |  |  |   |   |
|  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Neck lacerations and Compressed Asphyxia</i><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |  |  |  |   |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |  |   |   |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |  |  |  |   |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  |  |   |   |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>Found 3/27/97</b>   |  | 28b. Time of Injury<br><b>0014 HR</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>roadway</b>  |  | 28d. Describe how injury occurred<br><b>subject drove struck two cars and wall</b>   |  |  |   |   |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Interstate 695 near Charles Street in Baltimore County, Maryland</b>   |  |  |  |  |   |   |
| State Registrar  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>Theodore M. King</i>   |  | 29c. License number<br><b>OCME</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 27, 1997</b>                                    |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Theodore M. King</i>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |  |   |   |
|  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |  |  |  |  |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



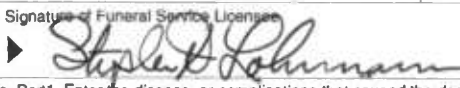

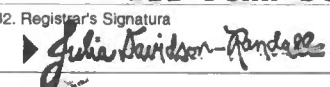
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09484

Reg. No.

|   |   |   |  |  |   |  |  |  |
|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE B. MONTZ, Jr.</b>                           |   |  |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> , Year <b>1997</b> |  | 3. Time of Death<br><b>2132 PM</b>                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>319 WEST LORRAINE AVENUE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                |  | 4c. County of Death<br><b>n/a</b>                            |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215 34 9199</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.                        |  | 8. Date of Birth (Month, Day, Year)<br><b>April 25, 1939</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>                                     |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>              |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>319 W. Lorraine Ave.</b>   |  | 10f. Zip Code<br><b>21211</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>                            |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Blacksmith</b>                    |  | 16b. Kind of Business/Industry<br><b>Steel Factory</b>   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Eugene B. Montz, Sr.</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie F. Finneran</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ines M. Stabler / daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1960 Kendall St., Edgewater, CO 80214</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   | 20d. Date<br><b>3/29/97</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br>a. <b>Pancreatic Cancer</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><b>partial</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28d. Describe how injury occurred  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>O.C.M.E</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 26, 1997</b>                     |  |  |
| 30. Name and address of person who completed causa of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |   |   |  | 32. Registrar's Signature<br>   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09485

|   |  |   |  |  |   |   |  |  |
|---|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>David Miller</b>                              |   |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b> |   | 3. Time of Death<br><b>10:55 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Liberty med. center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Balto. Md</b>              |   | 4c. County of Death<br><b>N.A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216 36 0259</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>2-13-40</b>  | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>  |
|   | Usual Residence of Decedent  |   |  |  |   |   |  |  |
| 10a. State<br><b>md</b>   |  | 10b. County<br><b>N.A</b>   |  | 10c. City, Town or Location<br><b>Balto-</b>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1433 Holbrook ST</b>   |  |   |  | 10f. Zip Code<br><b>21202</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Keeping</b>  |   |   | 16b. Kind of Business/Industry<br><b>med Examiner</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>SAMUEL MILLER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LESSIE RIVERS</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JANICE MILLER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1433 Holbrook St. Balto, Md. 21202</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEM</b>   |  | Date<br><b>3/31/97</b>   |   | 20c. Location - City or Town, State<br><b>LANDSDOWNE. MD</b>                                |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph B. Locks Jr.</b>   |  |   |  | 22. Name and Address of Facility<br><b>Locks Funeral Home 1304 N. Central Ave Balto Md 21202</b>   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Cancer of Lung</b><br>Due to (or as a consequence of):<br><b>b. Hypercalcemia</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>George E. Wicks III M.D.</b>  |  | 29c. License number<br><b>D41365</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>March 26, 1997</b>                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George E. Wicks III M.D. 2600 Liberty Heights Ave 21215</b>  |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0026

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 9058.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





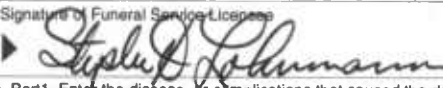
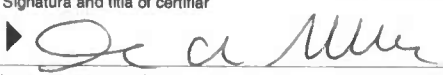
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09486

Certificate of Death

Reg. No.

|   |  |   |   |  |   |   |   |  |
|---|--|---|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Frank Anthony Noto</b>  |   |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>26</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>7:35 am</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Bel Forest Nursing &amp; Rehabilitation Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Forest Hill</b>  |   | 4c. County of Death<br><b>Harford</b>                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216 14 4075</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>March 24, 1924</b>            |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>n/a</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>6 E. Fort Ave.</b>   |  | 10f. Zip Code<br><b>21230</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b></b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Barber self employed</b>          |  | 16b. Kind of Business/Industry<br><b>Barber Shop</b>  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Enrico Noto</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Josephine Zanti</b>   |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dolores Noto / wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 E. Fort Ave., Baltimore, MD 21230</b>   |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |   | 20d. Date<br><b>3/28/97</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>                         |  |   |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Metastatic Lung Carcinoma</b><br>Dua to (or as a consequence of):<br>b. <b>Lung Cancer</b><br>Dua to (or as a consequence of):<br>c.<br>Dua to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |   |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b><br><b>COPD</b><br><b>Myocardial infarction</b>  |   |   |  |   |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |   |   |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br><b>022925</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3/26/97</b>                                       |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David McChesney 615 MacPhail Rd Bel Air MD 21014</b>   |  |   |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  | 32. Registrar's Signature<br>  |   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09487

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|--|--|---|---|--|--|---|---|--|---|------------------------------|---|---------------------------------|------------------|--|-----------------|----------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Aima Nechamkin</u>  |   |   |  | 2. Date of Death<br>Month <u>March</u> Day <u>27</u> Year <u>1997</u>  |   | 3. Time of Death<br><u>1138 am</u>                                      |  |   |                              |   |                                 |                  |  |                 |          |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Northwest Hospital Center</u>   |   |   |  | 4b. City, Town, or Location of Death<br><u>Baltimore, Md</u>   |   | 4c. County of Death<br><u>Baltimore</u>                                 |  |   |                              |   |                                 |                  |  |                 |          |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-01-2071</u>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>78</u> Yrs.  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>May 7, 1918</u>   |   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                    |   |                              |   |                                 |                  |  |                 |          |
|  | Usual Residence of Decedent  |   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
| To Be Completed by Funeral Director  | 10a. State<br><u>Maryland</u>  |   | 10b. County<br><u>Baltimore</u>   |  | 10c. City, Town or Location<br><u>Randallstown</u>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |                              |   |                                 |                  |  |                 |          |
|  | 10e. Street and Number<br><u>3709 Sonara Rd.</u>   |   |   |  | 10f. Zip Code<br><u>21133</u>  |   | 10g. Citizen of What Country?<br><u>USA</u>                             |  |   |                              |   |                                 |                  |  |                 |          |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |   |                              |   |                                 |                  |  |                 |          |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><u>8th Grade</u>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Homemaker</u>  |   | 16b. Kind of Business/Industry<br><u>Own Home</u>                       |  |   |                              |   |                                 |                  |  |                 |          |
|  | 17. Father's Name (First, Middle, Last)<br><u>Joseph Svehla</u>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Mary Filip</u>   |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Leo S. Nechamkin (Husband)</u>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3709 Sonara Rd. Randallstown, MD 21133</u>   |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Holy Family Cemetery</u>   |  | Data<br><u>3-29-97</u>   |   | 20c. Location - City or Town, State<br><u>Randallstown, MD</u>          |  |   |                              |   |                                 |                  |  |                 |          |
|  | 21. Signature of Funeral Service Licensee<br><u>John K. Al...</u>  |   |   |  | 22. Name and Address of Facility<br><u>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Rd. Randallstown, MD 21133</u>  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>CARDIAC ARRHYTHMIA</u></td> <td>Approximate Interval Between Onset and Death<br/><u>40 minutes</u></td> </tr> <tr> <td>b. <u>Myocardial Infarction</u></td> <td><u>1-3 hours</u></td> </tr> <tr> <td>c. <u>Atherosclerotic Cardiovascular Disease</u></td> <td><u>20 years</u></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> |   |   |  |  |   |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <u>CARDIAC ARRHYTHMIA</u> | Approximate Interval Between Onset and Death<br><u>40 minutes</u> | b. <u>Myocardial Infarction</u> | <u>1-3 hours</u> | c. <u>Atherosclerotic Cardiovascular Disease</u> | <u>20 years</u> | d. _____ |
| Immediate Cause (Final disease or condition resulting in death)  | a. <u>CARDIAC ARRHYTHMIA</u>   | Approximate Interval Between Onset and Death<br><u>40 minutes</u>   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  | b. <u>Myocardial Infarction</u>  | <u>1-3 hours</u>  |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  | c. <u>Atherosclerotic Cardiovascular Disease</u>   | <u>20 years</u>   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  | d. _____   |   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |                              |   |                                 |                  |  |                 |          |
|  |  |   |   |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                              |   |                                 |                  |  |                 |          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><u>M</u>                            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                          |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
| 29b. Signature and title of certifier<br><u>John Frederick Qualey MD</u>   |  |   |   | 29c. License number<br><u>D 21957</u>                      |  | 29d. Date signed (Month, Day, Year)<br><u>March 27, 1997</u>  |   |  |   |                              |   |                                 |                  |  |                 |          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Thomas Frederick Qualey MD Northwest Hospital Center ER Randallstown, Md 21133</u>  |  |   |   |  |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |
| 31. Date filed (Month, Day, Year)<br><u>MAR 31 1997</u>  |  |   |   | 32. Registrar's Signature<br><u>Julia Davidson-Randall</u> |  |   |   |  |   |                              |   |                                 |                  |  |                 |          |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 12 hours of death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09488

Item 16a,b, 20b,c Per FH FilmG745 3-31-97 rja

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                         | 1. Decedent's Name (First, Middle, Last)<br><b>JERRY NORRIS</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 21 1997</b>   |  | 3. Time of Death<br><b>9 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL OF BALTIMORE</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                                       | 5. Social Security Number<br><b>218-62-5584</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 7, 1954</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Usual Residence of Decedent   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Funeral Director                       | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>3325 Woodland Avenue</b>   |  | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unknown RECYCLING</b> |  | 16b. Kind of Business/Industry<br><b>SCRAP METAL unknown</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Howard Norris</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Della Locust</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mallene Norris Wiffe</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>905 Pennsylvania Avenue, Baltimore, Maryland 21201</b>   |  | 20. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in-state</b>                       |  |
|   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>Balt. MD 21227</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>   |  | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</b>  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b><br>Due to (or as a consequence of):<br><b>AIDS</b><br>Due to (or as a consequence of):<br><b>CRYPTOCOCCAL MENINGITIS</b><br>Due to (or as a consequence of): |  | Approximate interval between Onset and Death  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                     |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Mircea Todor, MD</b>   |  |
|   | 29c. License number<br><b>AS 2402321-MT9004</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 21 / 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MIRCEA TODOR<br/>SINAI HOSPITAL OF BALTIMORE 2401 W. BELVEDERE AVE, BALTIMORE, MD 21215</b>   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |
| 32. Registrar's Signature<br><b>John Davidson-Randall</b> |   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" on items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 09489**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Martin A. O'Neill</b>  |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>27</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:59 P.M.</b>                                   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| 5. Social Security Number<br><b>212-07-8800</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>4-11-1913</b>                 |  |
| 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Towson</b>                            |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>2300 Dulaney Valley Road</b>   |  | 10f. Zip Code<br><b>21204</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Tool &amp; Die Maker</b>          |  | 16b. Kind of Business/Industry<br><b>S. K. F.</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas Joseph O'Neill</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bridgett Fitzpatrick</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs Marie Griffith (Daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1329 Deep Run Lane, Reston, Virginia 20190</b>   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evergreen Memorial</b>   |  | 20c. Location - City or Town, State<br><b>3-31-97 Finksburg, Maryland</b>  |  | 20d. Date   |  |
| 21. Signature of Funeral Service Licensee<br><b>Wallace S. Brooks Jr.</b>   |  |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road, Towson, Md. 21204</b>  |  |   |  |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death) <b>MULTI-INFARCT DEMENTIA</b></b> |  |   |  | Approximate interval Between Onset and Death<br><b>72yrs.</b>  |  |   |  |
| 23b. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23c. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23d. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23e. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23f. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23g. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23h. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23i. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23j. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23k. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23l. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23m. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23n. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23o. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23p. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23q. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23r. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23s. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23t. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23u. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23v. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23w. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23x. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23y. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23z. Due to (or as a consequence of):   |  |   |  |  |  |   |  |
| 23aa. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ab. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ac. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ad. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ae. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23af. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ag. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ah. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ai. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23aj. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ak. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23al. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23am. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23an. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ao. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ap. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23aq. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ar. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23as. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23at. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23au. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23av. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23aw. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ax. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ay. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23az. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ba. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bb. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bc. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bd. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23be. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bf. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bg. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bh. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bi. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bj. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bk. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bl. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bm. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bn. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bo. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bp. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bq. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23br. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bs. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bt. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bu. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bv. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bw. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bx. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23by. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23bz. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ca. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cb. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cc. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cd. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ce. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cf. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cg. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ch. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ci. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cj. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ck. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cl. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cm. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cn. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23co. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cp. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cq. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cr. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cs. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23ct. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cu. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cv. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cw. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cx. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cy. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23cz. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23da. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23db. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23dc. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23dd. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23de. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23df. Due to (or as a consequence of):  |  |   |  |  |  |   |  |
| 23df. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |
| 23df. Describe how injury occurred  |  |   |  |  |  |   |  |
| 23df. Injury et Work?   |  |   |  |  |  |   |  |
| 23df. Time of Injury  |  |   |  |  |  |   |  |
| 23df. Date of Injury (Month, Day Year)  |  |   |  |  |  |   |  |
| 23df. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  |   |  |
| 23df. Manner of Death   |  |   |  |  |  |   |  |
| 23df. Pending investigation   |  |   |  |  |  |   |  |
| 23df. Accident  |  |   |  |  |  |   |  |
| 23df. Suicide   |  |   |  |  |  |   |  |
| 23df. Homicide  |  |   |  |  |  |   |  |
| 23df. Could not be determined   |  |   |  |  |  |   |  |
| 23df. Was case referred to medical examiner?  |  |   |  |  |  |   |  |
| 23df. Hospital:   |  |   |  |  |  |   |  |
| 23df. Inpatient   |  |   |  |  |  |   |  |
| 23df. ER/Outpatient   |  |   |  |  |  |   |  |
| 23df. DOA   |  |   |  |  |  |   |  |
| 23df. Other:  |  |   |  |  |  |   |  |
| 23df. Nursing Home  |  |   |  |  |  |   |  |
| 23df. Residence   |  |   |  |  |  |   |  |
| 23df. Other (Specify)   |  |   |  |  |  |   |  |
| 23df. Certifier   |  |   |  |  |  |   |  |
| 23df. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |
| 23df. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |
| 23df. Signature and title of certifier  |  |   |  |  |  |   |  |
| 23df. License number  |  |   |  |  |  |   |  |
| 23df. Date signed (Month, Day, Year)  |  |   |  |  |  |   |  |
| 23df. Name and address of person who completed cause of death (Item 23e) (Type, Print)  |  |   |  |  |  |   |  |
| 23df. Kendall Faulkner, M.D. 2300 Dulaney Valley Road, Towson, Md. 21204  |  |   |  |  |  |   |  |
| 23df. Date filed (Month, Day, Year)   |  |   |  |  |  |   |  |
| 23df. Registrar's Signature   |  |   |  |  |  |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09490

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **Ann Marie Pukita** 2. Date of Death Month **March** Day **27** Year **1997** 3. Time of Death **7:45 am**

4a. Facility Name (If not institution, give street and number) **Johns Hopkins Bayview Medical Ctr.** 4b. City, Town, or Location of Death **Baltimore City** 4c. County of Death **N/A**

Funeral  
Director

5. Social Security Number **220-14-3300** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **86** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **June 1, 1910** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Baltimore** 10c. City, Town or Location **Edgemere** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **2825 Apt. 412 Lodge Farm Road** 10f. Zip Code **21219** 10g. Citizen of What Country? **United States**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **3 Years** College (1-4 or 5+) **College** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **Ignatius Jankowski** 18. Mother's Name (First, Middle, Maiden Surname) **Marcianna Szypienski**

19a. Informant's Name/Relationship (Type, Print) **Jean E. Doty/ Daughter** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **8106 Elenor Terrace Dundalk, Maryland 21222**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Sacred Ht. of Mary Cem.** Date **4/2/1997** 20c. Location - City or Town, State **Dundalk, Maryland**

21. Signature of Funeral Service Licensee **Johnny L. Gask** 22. Name and Address of Facility **Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Coronary Artery Disease** e. Due to (or as a consequence of): **3 years**

b. **Parkinson's Disease** Due to (or as a consequence of): **5 years**

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Harjit Singh, M.D.** 29c. License number **D14160** 29d. Date signed (Month, Day, Year) **03/28/97**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225**

31. Date filed (Month, Day, Year) **MAR 31 1997** 32. Registrar's Signature **John Davidson-Randall**

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. This should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If death is caused by any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09491

Items: 23 part I, 27 per ME0 G-746 4/16/97 reb Certificate of Death

Reg. No.

|   |  |   |   |  |   |  |  |                                     |  |
|---|--|---|---|--|---|--|--|-------------------------------------|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>MAURICE POTEAT</b>                          |   |   |  |   | 2. Date of Death<br>Month <b>MARCH</b> Day <b>24</b> , Year <b>1997</b>          |  | 3. Time of Death<br><b>11:10 AM</b> |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3532 LYNDALE AVE.</b> |   |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                         |  | 4c. County of Death<br><b>n/a</b>   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>212-82-3334</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>NOV-23, 1958</b>  |                                     | 9. Birthplace (State or Foreign Country)<br><b>BALTIMORE, MD</b> |
|   | Usual Residence of Decedent  |   |   |  |   |  |  |                                     |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>m/a</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                     |  |
| 10e. Street and Number<br><b>3532 LYNDALE AVENUE,</b>   |  |   |   | 10f. Zip Code<br><b>21213</b>  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                            |  |                                     |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |                                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 th</b> College (1-4 or 5+) <b>-</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>  |   |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |                                     |  |
| 17. Father's Name (First, Middle, Last)<br><b>GEORGE POTEAT</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PAULINE</b>   |  |  |                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GEORGE POTEAT</b>  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2822 E. CHASE STREET, BALTIMORE, MD</b> |  |  |                                     |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>VOSHALL MEMORIAL GARDENS 3-28 DUNDALK, MD</b>  |  |   | 20c. Location - City or Town, State  |  |                                     |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   |  | 22. Name and Address of Facility<br><b>WM. C. MARCH FH.-1101 E. NORTH AVE. 21202</b>  |  |  |                                     |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>CIRRHOSIS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |   |  |  |                                     | Approximate Interval Between Onset and Death                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                     |  |
|   |  |   |   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                     |  |
|   |  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                     |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |                                     |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                     |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |  |  |                                     |  |
| 29b. Signature and Title of certifier<br>  |  |   |   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MARCH 25, 1997</b>   |                                     |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |   |  |  |                                     |  |
| 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  |   |   |  | 32. Registrar's Signature<br>                            |  |  |                                     |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 09492

|   |  |   |   |  |   |  |  |  |
|---|--|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>ERMA GERALDINE PAUL  |   |   |  | 2. Date of Death<br>Month Day Year<br>March 30, 1997  |  | 3. Time of Death<br>4:27 a.m.                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Stella Maris Hospice   |   |   |  | 4b. City, Town, or Location of Death<br>Towson  |  | 4c. County of Death<br>Baltimore                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br>220 38 9909   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>56 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>April 28, 1940            |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |   | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Edgemere                          |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>2926 Wells Ave.   |  | 10f. Zip Code<br>21219-1243   |  | 10g. Citizen of What Country?<br>United States                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Assistant Manager                        |  | 16b. Kind of Business/Industry<br>Retail Clothing Store   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Ernest Young  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Erma Geraldine Custer  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Dale R. Paul / son   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1800 Sandee Ct., Edgewood, MD 21040  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Crematory   |  | 20c. Date<br>3/31/97  |  | 20d. Location - City or Town, State<br>Baltimore, MD             |  |
|   | 21. Signature of Funeral Service Licensee<br>Stephen D. Lohrmann   |   |   |  | 22. Name and Address of Facility<br>CAFA Stephen D. Lohrmann P.A.<br>8717 Green Pastures Dr., Baltimore, MD 21286   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. LIVER CANCER<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>2 yrs. |   |   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE |   |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. Signature and title of certifier<br>Kendall Faulkner<br>29c. License number<br>D25643<br>29d. Date signed (Month, Day, Year)<br>3/31/97 |  |   |   |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204   |  |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAR 31 1997  |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |   |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09493

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>AMIL MATTHEW PERTICONE</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>25</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:50 A.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GENESIS ELDERCARE - CROMWELL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-07-9573</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>1/1/09</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>TOWSON</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6 AIRWAY CIRCLE #2A</b>  |  | 10f. Zip Code<br><b>21286</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4th GRADE</b><br>College (1-4 or 5+) <b>COLLEGE</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>WELDER</b>  |  | 16b. Kind of Business/Industry<br><b>BETHLEHEM STEEL</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>ANGELO PERTICONE</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JOSEPHINE PERTICONE</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>FRANK CIOCILO BROTHER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1300 HEATHER HILL ROAD BALTIMORE, MD 21239</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GAR.</b>   |  | 20c. Date<br><b>3/28/97</b>   |  | 20d. Location - City or Town, State<br><b>COCKEYSVILLE, MD</b>   |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br><b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic coronary artery disease</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>121022</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>3-25-97</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. KOWALOWSKI MD 8604 HANFORD RD BALTO. MD 21234</b>   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |  | 32. Registrar's Signature<br>   |  | 33. Registrar's Title<br><b>Registrar</b>  |  | 34. Registrar's Office<br><b>State Registrar</b>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be submitted within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 09494

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn R. Rorke

2. Date of Death

March

Day

30

Year

1997

3. Time of Death

12:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Cherrywood Healthcare

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

5. Social Security Number

219-28-3263

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 24, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

106 Highgate Court

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Norman McCullough

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Smith

19a. Informant's Name/Relationship (Type, Print)

Allen Dudley Rorke, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Highgate Court, Owings Mills, Md. 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Saters Church Cem. April 1, 1997

Date

20c. Location - City or Town, State

Lutherville, Md.

21. Signature of Funeral Service Licensee

H. J. Schmitt

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd., Owings Mills, Md. 21117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. J. Schmitt MD

29c. License number

D27034

29d. Date signed (Month, Day, Year)

March 31 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. H. Copeland MD 5310 Old Court Road Randallstown MD 21133

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1944

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1965

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State of Maryland / Department of Health and Mental Hygiene

97 09495

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |  |
|---|--|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Howard Frank Richter</b>                    |  |  |  | 2. Date of Death<br>Month <b>March</b> Day <b>28</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:00 PM</b>                         |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care Towson</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>                 |  | 4c. County of Death<br><b>Baltimore</b>                     |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>269-03-1593</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>March 25 1908</b> |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                                    |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore</b>                                       |  | 10c. City, Town or Location<br><b>Hydes</b>                 |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>12520 Regwood Rd.</b>   |   | 10f. Zip Code<br><b>21082</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>+2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>General Motors</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>George Herman Richter</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Barbara Lorentz</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary J. DeFontes/Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12520 Regwood Rd. Hydes, Md. 21082</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Old St. Josephs Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>4-1-97 Cincinnati, Ohio</b>            |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>dehydration</b><br>Due to (or as a consequence of):<br>2 weeks<br>f. <b>dysphagia</b><br>Due to (or as a consequence of):<br>8 weeks<br>g. <b>stroke</b><br>Due to (or as a consequence of):<br>8 weeks<br>h. _____<br>Due to (or as a consequence of): |   | Approximate Interval Between Onset and Death   |   |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>declined gastrostomy, HTN, ASCVD</b>  |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D41104</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>3 29. 97</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Theodore C. Houk, MD. 7825 York Rd. Towson, Md. 21204</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  | 32. Registrar's Signature<br>  |   |  |   |  |  |

Baltimore, Maryland 21215-8020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", "Accident", "Suicide", or "Homicide", the Medical Examiner must be notified at once.

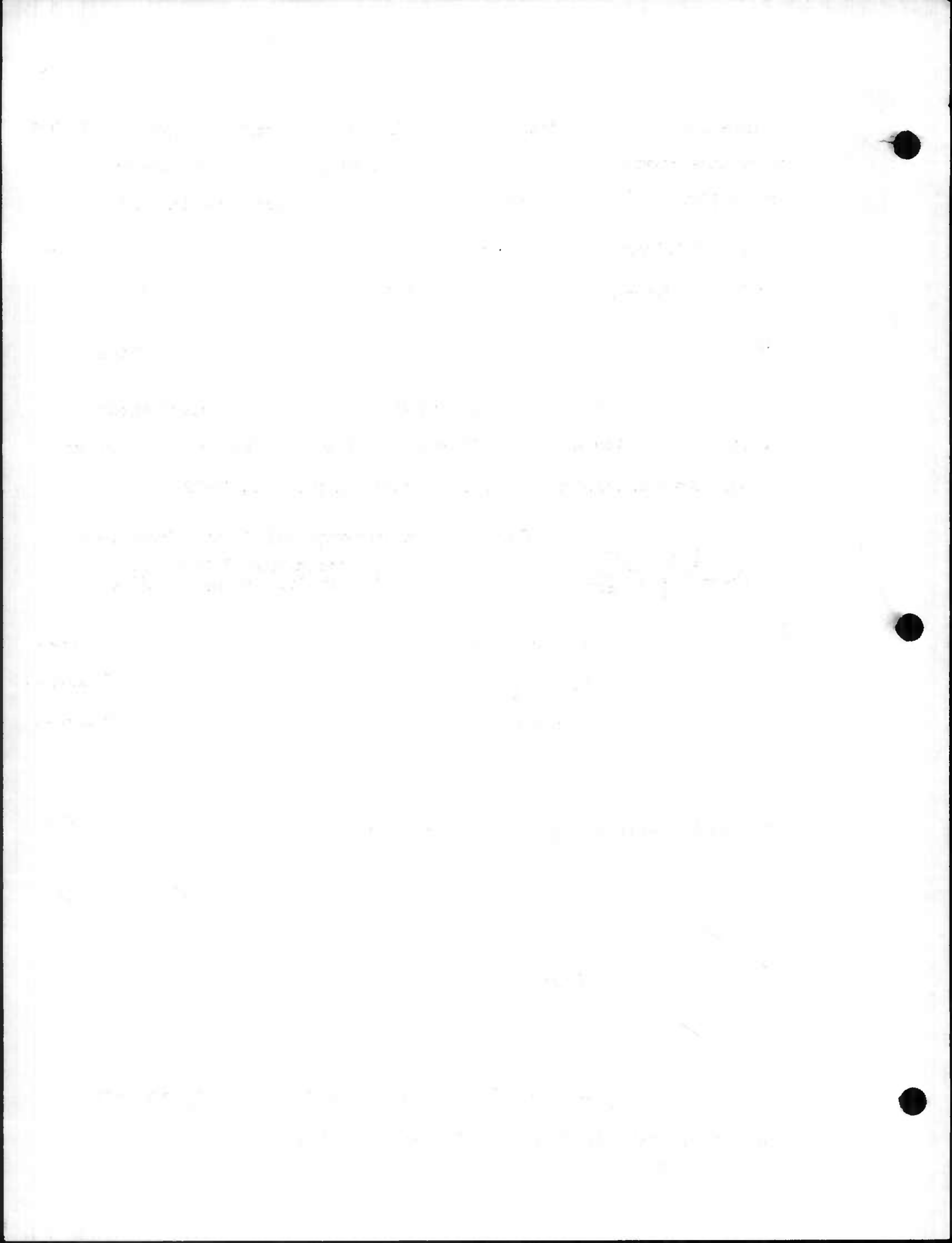
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09496

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys NoraLee Rudasill

2. Date of Death

Month Day Year  
Mar 28, 1997

3. Time of Death

4:00 AM

4e. Facility Name (If not institution, give street end number)

1948 Littlestown Pike

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

212-30-0796

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 30, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

1948 Littlestown Pike

10f. Zip Code

21158

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Wrapper

16b. Kind of Business/Industry

Super Fresh Stores

17. Father's Name (First, Middle, Last)

Harry

Subock

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Krickbaum

19a. Informant's Name/Relationship (Type, Print)

Mrs. Sharon Glacken

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

1948 Littlestown Pike Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Mem. Park

Date

3/31

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.  
8728 Liberty Road Randallstown, MD 2113323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Atherosclerotic Coronary Vessel Disease 10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

032082

29d. Date signed (Month, Day, Year)

3/31/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert L. Moore 114 Business Center Dr. Reisterstown MD 21136

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

21136

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09497

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

August Rampmeyer

2. Date of Death

Month

Day

Year

3. Time of Death

7:42 PM

4a. Facility Name (If not institution, give street and number)

Univ of MD Shock Trauma

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

unknown

6. Sex

M 2 F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

unknown

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 Yes 2 No

Maryland

Baltimore

10a. Street and Number

1236 W. Ostend Street

10f. Zip Code

21230

10g. Citizen of What Country?

unknown

11. Marital Status

1 Navar Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates

unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:  
unknown

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
unknownCollege (1-4 or 5+)  
unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Summa)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify) in-state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myoglobinuria

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

36 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Fall

Due to (or as a consequence of):

48 hours

c. Intoxication

Due to (or as a consequence of):

48 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

12-31-96

28b. Time of Injury

UNK

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

Subject fell off his head

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1236 W. Ostend St, Baltimore, MD

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Trauma/Critical Care Fellow

29c. License number

P 10723

29d. Date signed (Month, Day, Year)

1/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANISH TANDON 29 S. GREENE ST, BALTIMORE

31. Date filed (Month, Day, Year)

MAR 28 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

File 1/27/97



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 09498

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Marie M. Starka

2. Date of Death

Month Day Year  
MARCH 25, 1997

3. Time of Death

5:45 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-05-7140

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 26, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

975 Dalton Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

August Miller

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Woytowicz

19a. Informant's Name/Relationship (Type, Print)

Mr. James Starka/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

975 Dalton Ave. Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Pk. 3/28/1997

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

Phary L. Glick

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Brain Stem Infarct  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial Fibrillation & multiple CVAs  
Due to (or as a consequence of):

5 years

c. Vertebrobasilar Insufficiency  
Due to (or as a consequence of):

6 years

d. Hypertension

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Leonard Kassir, M.D.

29c. License number

D1299654

29d. Date signed (Month, Day, Year)

MARCH 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leonard Kassir Union Memorial Hospital 201 E. University Pkwy Baltimore, MD 21218

31. Date filed (Month, Day, Year)

MAR 31 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 09499

Items:8,17 per Informant G-758 4/17/98 reb Certificate of Death

Reg. No.

|  |   |   |   |                                |  |
|--|---|---|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Sylvia Sanders</b>   |   | 2. Date of Death<br>Month <b>March</b> Day <b>29</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>6:30 Am</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN</b>   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>MD</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>24-24-1859</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>68</b>   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth<br><b>5/19/28</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |                                |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent   |   | 10a. State<br><b>MD</b>   |                                |  |
|  | 10b. County<br><b>NIA</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |                                |  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |                                |  |
|  | 10e. Street and Number<br><b>104 CATOR AVENUE</b>   |   | 10f. Zip Code<br><b>21218</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |   |   |                                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11TH GRADE</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CASHIER</b>   |                                | 16b. Kind of Business/Industry<br><b>GROCERY</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>GEORGE GRACE GRACEY</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIRGINIA STATEN</b>   |                                |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>DARRELL SANDERS / SON</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4207 PARKTON STREET, BALTIMORE, MD 21229</b>  |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DRUID RIDGE CEMETERY</b>   |                                | 20c. Location - City or Town, State<br><b>4.2.97</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Greene</b> |   | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE<br/>5151 BALTO. NAT'L PIKE, BALTO. MD 21229</b> |   |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Brain Hypoxia</b><br>Due to (or as a consequence of):<br>b. <b>Sepsis</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |                                | Approximate Interval Between Onset and Death<br><b>Two days</b><br><b>Five days</b>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>End stage renal disease</b><br><b>Diabetes mellitus</b>  |   |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |                                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |                                |  |
|  | 29b. Signature and title of certifier<br><b>J. had Pausy, MD</b>  |   | 29c. License number<br><b>P10584</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>March 29, 1997</b>   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Good Samaritan Hospital<br/>5601 Loch Raven Blvd Baltimore, M.D 21239</b>  |   |   |                                |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>   |   | 32. Registrar's Signature<br><b>Shirley Davidson-Randall</b>  |                                |  |

Baltimore, Maryland 21215-6020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 28a or 28b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

97 09500

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Clairine Shaver</b>   |  |   |  | 2. Date of Death<br>Month <b>March</b> Day <b>22</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>5:52 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bayview Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>233 26 5756</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 2, 1922</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>7729 Wynbrook Rd.</b>  |  | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Domestic</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Loy</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Genevive Powell</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John H. Shaver / husband</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7729 Wynbrook Rd., Baltimore, MD 21224</b>   |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Stephen D. Lohrmann</b>  |  | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>hemorrhage</b><br>Due to (or as a consequence of):<br><b>coagulopathy</b><br>Due to (or as a consequence of):<br><b>sepsis</b><br>Due to (or as a consequence of):<br><b>endocarditis</b> |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1 1/2 months</b><br><b>1 1/2 months</b><br><b>1 1/2 months</b><br><b>2 months</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NQWMI, CHF, ARF</b>   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b></b>  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred<br><b></b>   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  | 29b. Signature and title of certifier<br><b>Paul Usual MD</b>  |  |
|   | 29c. License number<br><b>N3195</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>March 24 1997</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Fred Hsieh MD</b><br><b>Johns Hopkins Bayview Medical Center</b>  |  |   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>MAR 31 1997</b>  |  |
|   | 32. Registrar's Signature<br><b>John Randall</b>   |  |   |  |   |  | 33. Date of Death<br><b>March 22 1997</b>  |  |

